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ABSTRACT

This report of a conference contains an introduction to the problem of drug use among pregnant women and the following presentations: (1) "Impact of Crack Cocaine and Other Drugs on Mothers and Children" (Margaret Lynn Yonekura); (2) "Providing Continuous and Comprehensive Services" (Neal Halfon); (3) "Stretching Resources To Reach Increasing Numbers of Families" (Xylina Bean); (4) "Ethical Dilemmas and Public Policy" (David Chavkin); (5) "Generations At Risk to the Nightmare of Addiction" (Gina Barclay-McLaughlin); (6) "The Mandela House Program: Recovering Mothers Speak" (Minnie Thomas); and (7) "A Political Overview from California" (Diane Watson and Jackie Speier). Highlights are presented from 10 workshops conducted at the conference: The Impact of Drug Exposure on the Development of Infants and Toddlers; Prevention Efforts in the Public Schools; Health Issues of Alcohol and Drug-Exposed Babies; Working With Families Impacted by Addiction; Ethical, Legal, and Policy Implications of Substance Abuse During Pregnancy; Caring for Drug- and Alcohol-Exposed Babies; Following Drug-Exposed Babies to School; Social Service and Foster Care Issues; Chemical Dependency Treatment for Pregnant Addicts; and Building Coalitions and Interagency Collaborations. Appendices contain the conference program agenda and presenter contact directory. (NB)

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Proceedings Papers December 1989

A Conference on Drug Free Pregnancy

Far West Laboratory for Educational Research and Development

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This conference grew out of one of the most urgent problems facing the communities we serve. As Far West Laboratory (FWL) and other agencies began planning the collaborative Bay Area Early Intervention Project, we found we could not proceed without first dealing in some fundamental way with the growing numbers of women without prenatal care who were giving birth to drug-exposed infants. We commissioned psychologist **Diana Kronstadt** to research interventions being done nationwide. Feedback on her resulting 1989 report *Pregnancy and Addition: Impact and Treatment* made it clear that people from a range of disciplines struggling with pieces of this problem needed a forum for exchanging knowledge and ideas.

For making the conference happen, we would like to thank conference planner **Kathy Daugherty** and staff **Barbara Piper** and **Charlie Brewer**.

Many others at FWL also made valuable contributions. We thank Fredrika Baer, Ralph Baker, Beverly Beauchamp, Donna Bellorado, BethAnn Berliner, Kathy Bertolucci, John Brownfield, Carol Burkhart, Debi Hertz, Terri Johnson, J. Ronald Lally, Bonnie Lurie, Tom Ross, Doris Smith, Kendyll Stansbury and Carol Young-Holt. Design credit goes to Fredrika Baer and Patricia Christen.

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Introduction

Crack. The rallying word for the war on drugs whose very mention conjures up images of crime, violence, personal agony and family tragedy. But for some 250 people gathered near San Francisco for a Far West Laboratory conference in early December, crack was mere shorthand for the spectrum of drugs, legal and illegal, that are addicting staggering numbers of Americans. "A Conference on Drug Free Pregnancy," while broad in its topics and crossing disciplines from education to medicine, social services, and public policy, had a very specific focus: the estimated 375,000 babies a year who become the drug epidemic's victims in utero and whose best hope is changing the lives of drug-using mothers before pregnancy occurs.

For educators, that means incorporating wide-ranging drug prevention and intervention programs from the earliest grades — programs that promote health, self-esteem and family responsibility. It also means redefining early intervention, since a child's ability to succeed later in school is influenced not just by his experiences at age three or four but by aspects of his prenatal development and first weeks of life. For drug-exposed babies already reaching school age, a few educators have begun creating special programs that determine and attend to their special needs.

What's obvious in all these efforts is that the drug epidemic, rooted in large societal problems, can't possibly be resolved by educators — or anyone else — alone. Programs must be comprehensive and mounted collaboratively by multiple community agencies to have any hope of success. This is no revelation to health and social service workers. Struggling daily with drug-related crises that overwhelm their caseloads, these professionals are only too aware of the futility of piecemeal heroics.

In fact, multi-agency collaboration is on everyone's lips as the one logical means of creating the elaborate and far-reaching kinds of programs that are needed. Such broad-scale collaboration, however, is easier said than done. Few models exist, and attempts to bridge disciplines can seem like overtures across species. But with a flashpoint as stirring as the exponential increase in babies born addicted and often seriously impaired by drugs, the urgency to act can overcome hurdles — as this conference compellingly showed.

The Facts and Figures

Over two days of major sessions and concurrent workshops, the conference coupled a disturbing array of facts and figures with a moving vision, provided by five young mothers, of the changes possible when pregnant addicts get help. Participants themselves reflected the diversity of interests touched, from obstetricians and pediatricians to foster mothers, social workers, school officials, classroom volunteers, lawyers, political activists and psychologists.

Major speakers included physicians from the few centers around the nation actually attempting to intervene with chemically dependent mothers and drug-exposed infants. They explained the medical crises for mother and baby, the complex overlaps with psycho-social issues, and the kinds of programs they have built and see a pressing need to expand on, even in the face of uphill funding battles. Nationwide it is estimated that the number of drug-exposed newborns has tripled since 1985. And in counties like Los Angeles, that increase is fivefold, according to Dr. Margaret Yonekura, chief of maternal and fetal medicine at Harbor (UCLA) Hospital and director of Harbor's three-year-old, in-house clinic for pregnant addicts.

Yonekura reported that whether the primary drug used is cocaine, an opiate or PCP, pregnant women — like other addicts — use multiple substances. Indigent women often further compound the risks to themselves and their infants by turning to prostitution to support their habits. Sexually transmitted organisms such as gonorrhea and chlamydia can lead to premature delivery or be passed on to the baby, who is already at greater risk of low birth weight, infections or anomalies.

And that's just for starters. Upon discharge from the hospital, these infants face double jeopardy. In fragile health and probably going through drug withdrawal, they need skilled and sensitive care. Yet they are released to mothers so troubled themselves that they cannot care for any baby, much less a hurting one. For exactly this reason, Dr. Neal Halfon once believed that all of these babies should be taken from their mothers and placed in foster care. But over the last three years as director of the Center for the Vulnerable Child at Oakland (Calif.) Children's Hospital, he's been convinced that this view is shortsighted, resulting in perpetually overburdened health and foster care systems as the untreated mother returns to the same lifestyle and gives birth to more damaged babies.

Now Halfon feels that "much can be done for this population" — through a mother-child continuum of care, starting prenatally and continuing through the child's early years. The trouble is, no such all-inclusive program yet exists, largely because of a lack of community services to support it. Most live-in drug treatment centers, for example, turn away pregnant women. But there are some programs attempting comprehensive care. Halfon and his colleagues identified 10, each striving to treat not just the medical disease of chemical dependency, but its roots in psychological and relationship dysfunction. He applauds programs like Yonekura's that are "user friendly." Instead of referring clients to services all over town, they do their best to provide "one-stop shopping" on-site.

Influencing Policy

Setting up intensive, large-scale programs clearly calls for a major investment of resources. This is difficult from the outset, since funding always flows more readily to quick cures than to prevention. But even those policymakers who advocate long-range programs can't gain support without information to help them analyze costs and benefits. And as yet, no one has done the research. Halfon argued strongly for getting it done, by evaluating the effectiveness of existing programs and by documenting outcomes. How, for example, do babies living with biological mothers fare compared with those in foster care?

One thing that isn't a problem is getting policymakers' attention. Crack has taken care of that. "The nice thing about cocaine is, it made the general society decide that this problem may actually affect everyone," explained Dr. Xylina Bean, associate professor of pediatrics at King-Drew Medical Center in impoverished Watts in south-central Los Angeles. For years Bean "couldn't get a lick of money from nobody to do nothin'" for PCP users. But she now hopes for a "trickle down effect" from crack's notoriety.

At King, Bean has managed to create a series of programs for mothers and babies, particularly targeting women who have custody or are their baby's primary caregiver. Using volunteers to stretch scarce dollars, she has pieced together services for those who want to go beyond drug recovery to wholly changing their lives. She railed against California's "ridiculous" drug-specific policies — "money for drugs goes here, money for alcohol goes there" — and its legislation that separates treatment for women and children. "Children," she said, "are an afterthought."

Inspiration from Those Who've Been There

Not to Minnie Thomas, director of Oakland's pioneering Mandela House, a treatment home for mothers and babies that will soon expand, funding allowing, to a second home and a total of 12 beds. Thomas, who once worked in offender and ex-offender drug programs, saw that pregnant women were excluded. As a mother, she chafed at the philosophy that babies of drug-addicted women should be taken away at birth. Her determination to find a better way led her to found Mandela House in 1987.

When Thomas and her panel of five young mothers, all recovering addicts, came up to address the conference, remote facts and figures came alive with names and faces — young, hopeful faces. Thomas spoke first, explaining the program. It is year-long,

voluntary and based on the belief that drugs are a symptom of underlying problems that must be identified and addressed. She described daily routines that include classes in the effects of drugs, parenting, child development and grooming as well as group counseling and meetings of programs such as Alcoholics Anonymous.

Then each of the mothers took the microphone. With striking repetition, they told of childhood abuse. One had been sexually molested at eight; another introduced to drugs as a young teen by her father. For each, drugs had beckoned as an escape from pain, and each told of finding devastation instead. They spoke now of determination to revamp their lives. But doing so, they said, meant confronting long-numbed pain. "On drugs you lose touch with anger, happiness and sadness," said the woman named Tammy. "In sobriety, it all dumps on you. You feel. And then you have to learn to deal with those feelings clean and sober."

That struck a chord with Gina Barclay-McLaughlin, who followed the Mandela House panel with her soft-spoken message of outrage on behalf of society's throwaways. "We shouldn't even have to debate whether Minnie Thomas gets more beds," she said, "or whether more money should go to housing so that we can have quality settings for people who need places to live." McLaughlin has directed the Beethoven Project in Chicago, an early childhood intervention program regarded as a model by educators around the country. Its location is the Robert Taylor homes — the nation's largest and most impoverished public housing project where the daily trauma of living in appalling conditions is compounded by drugs and violence.

McLaughlin expressed deep anger with those who compare kids from the projects with suburban kids and find them lacking. In fact, she said, these children are highly competent — in skills undreamed of in suburbia but vital to survival in the projects, the only world they've ever known. Children there, she said, grow up learning not to feel. Without choices in their lives, they adapt in ways that some may call dysfunctional but to McLaughlin are admirably creative. "I think it's a basic requirement for any society that children should feel protected. And unless that happens, we're all going to be frightened with the kind of future we are building."

Politics: Funding Debates and Ethical Dilemmas

Making the major kinds of changes McLaughlin called for means finding the political will. And two California legislators offered insights into where that process stands in that state, regarded by many as the nation's laboratory for social change. State Senator Diane Watson (D-Los Angeles), an outspoken advocate of prevention programs, finds pragmatic support for her position in the extraordinary burdens that chemically dependent pregnant women place on the system. In California, 30,000 babies a year are born to addicts, accounting for a major portion of the state's $178 million annual tab for newborn medical care. Beyond that are the costs for child welfare services, foster care placement, specialized training for foster parents and special education.

Growing numbers of drug babies, said Watson, can only mean that the state's general health and social services for low-income women and children — theoretically prevention-oriented — are inadequate. "We *are* starting to act," she said, "but our focus is still on the back end rather than on prevention."

Assemblywoman Jackie Speier (D-San Mateo County) described the fate of AB741, the bill she introduced last year for the treatment and care of at-risk pregnant women. Speier's bill called for sensitively identifying women who are at risk, expanding statewide capacity to provide comprehensive treatment services, and ensuring coordination of the various state and county drug, alcohol and social services. Despite unanimous passage in the Senate, the bill was vetoed by Governor George Deukmejian who contends that no one yet really knows how to help pregnant women. "We do know what to do," counters Speier. "What limits us is a lack of state commitment to do it." Noting that 5400 women are now on waiting lists for treatment centers, she adds, "The victims will be a generation of children."

The political thicket grows all the more dense as the arguments become entangled with the abortion debate. This is acutely true on Capitol Hill, according to David Chavkin, a Washington-based lawyer and policy director of the National Center for Clinical Infants Programs. The controversy hinges on fetal rights, and the question at hand is whether pregnant addicts should be prosecuted for violating child abuse statutes. Anti-abortion forces generally favor criminalization. But the threat of prosecution will lead

to more abortions — exactly the outcome this group doesn't want. Those on the pro-choice side want no governmental intervention and say the fetus has no rights until birth. Again a problem, said Chavkin, since under *Roe v. Wade* the fetus does have the right to due process at the point of viability.

He pointed out that using illegal drugs is already a criminal act. So the issue really isn't criminalization, but selective prosecution of pregnant women. He described a newly formed coalition of middle-grounders focused not on whose rights are violated, but on what works. In the short term that may be mandating that pregnant addicts get treatment. Longer term, it may mean re-building employment and poverty programs dismantled during the early Eighties "so that we're not just putting on band-aids after people reach the end of their ropes," as Neal Halfon put it. Whatever it takes, the cry to make change happen is coming in anguish from the nation's nurseries. Giving that cry a political voice is clearly the task at hand.

The Impact of Crack Cocaine and Other Drugs on Mothers and Children

*Obstetrician **Margaret Lynn Yonekura** is Chief of Maternal Fetal Medicine at Harbor-UCLA Hospital. She directs a comprehensive and sensitive intervention program for pregnant addicts — the only such program in Los Angeles that is housed in an obstetrical/prenatal clinic.*

It's clear that the number of cases of neonatal drug withdrawal has been rising exponentially. For example, in Los Angeles County, there were only 500 such babies reported to the Department of Children's Services in 1985. By 1988 the number had risen to well over 2500. Given this rate of growth, one could anticipate that by 1991 in Los Angeles County alone we would have 10,000 such babies reported. So the charge of all of you attending this conference is to help us stop the spread of this epidemic and drive this number back down again.

Addiction is Colorblind, Law is Not

In 1986 it was estimated that approximately 10 percent of women in an average obstetrical practice were using cocaine. And at that same time at Harbor General Hospital we did a little study of women coming into our emergency room with signs and symptoms of spontaneous miscarriage. We found that eight percent of women with that particular obstetrical complication did admit to cocaine use during pregnancy. So we felt that the estimate was fairly accurate, though probably an under-representation of the overall magnitude of the problem.

More recently, Ira Chasnoff of Northwestern Hospital in Chicago conducted a study in Pinellas County, Florida where he used blind urine specimens of every woman presenting herself for routine prenatal care, both at public health clinics and private medical practices. The study included about 600 such women, equally divided between the public and private sector. Chasnoff found that 14.8 percent tested positive for either alcohol, marijuana, cocaine or opiates. Now we all know that this group is at lower risk than those women who have no prenatal care and instead come into our hospitals only at the time of labor and delivery.

"So I do drugs. Who's going to know?' Obviously, the fetus is going to know."

In Chasnoff's study, there was no significant difference between the incidence of drug use in the public and private sector, nor between black and white women. There were some differences, however, in the kinds of drugs found in the urine. Black women had more cocaine; white women had more marijuana. And, somewhat frighteningly, a black woman who used drugs was almost 10 times as likely to be reported to authorities than a white woman. That is a phenomenon we see throughout our country today.

Dangerous Substances Are Not All Illegal

Although this talk will focus on illicit drugs and their effects on pregnancy and the newborn, I think it's important to realize that some licit drugs may in fact be more of a problem. Two to 13 percent of women in North America drink enough during pregnancy to pose a significant risk to their fetuses. Alcohol is one of the leading known causes of birth defects and mental retardation in the U.S. — leading the list over Down's Syndrome and neural tube defects. In California, we have an excellent screening program to detect fetuses with Down's Syndrome and neural tube defects. However, we have no good screening program for alcohol problems during pregnancy. That's something we need to address, and quickly.

And what about smoking? One third of pregnant women smoke. Smoking poses a significant risk of fetal growth retardation and perhaps long-term learning problems later, though this is less clear. It is another habit that we need to get rid of.

Whether the primary drug used by the woman is cocaine, opiates or PCP, it's important to recognize that women use multiple substances. You can't say, "This woman is just a cocaine addict" or "This one uses only opiates." Even if they think they are using only one drug, they may be getting multiple drugs unknowingly because their dealers often mix things up. And about a third of addicts who use illicit drugs also significantly abuse alcohol. Many also use marijuana, and about 50 percent smoke cigarettes. A commonly seen combination is an upper, such as cocaine, combined with a downer, such as marijuana, alcohol, or barbiturates. This is a very typical drug use pattern and again emphasizes the fact that these women are polydrug users.

Before I continue, let me show you a cartoon. It depicts a pregnant woman sitting on the couch. "So I do drugs," she's saying. "Big deal. Who is going to know?" Obviously, the fetus is going to know.

Common Obstetrical Complications: Prematurity

Pregnant women who use drugs and alcohol have an increased incidence of premature labor and delivery. In fact, at least 30 percent deliver prematurely. They have an increased incidence of intrauterine growth retardation; congenital infections, including syphilis and HIV; congenital anomalies or birth defects; and an increased perinatal mortality rate.

Why an increased risk for *premature labor and delivery*? Well, one of the reasons is that they have an increased incidence of vaginitis and cervicitis and of cervical and vaginal infections such as gonorrhea and chlamydia, to name but a few. Why do they have this increased risk of sexually transmitted diseases? Because many of the indigent addicts support their habit by prostitution. And many of the organisms they pick up will trigger the cascade that leads to premature contractions. Additionally, because of these local infections in the cervix or the vagina, they are at increased risk for prematurely rupturing their bag of water. And if that occurs pre-term — before 37 weeks — there's a very high likelihood that the baby will be born soon thereafter.

Then there are the more drug-specific effects themselves. For one thing, the drugs increase the level of circulating catecholamines, which then stimulate the uterus to begin contracting. Moreover, many of the drugs decrease the blood flow to the uterus, and that causes some degree of hypoxia of the myometrial muscle, which again triggers contractions.

Finally, many of these drugs are related to anaesthetic agents that cause numbing. PCP, for instance, was originally developed as a veterinary tranquilizer. It is related chemically to a drug known as ketamine. Cocaine is related chemically to the drug lidocaine that you get in the dentist's office to numb your mouth. With many of the drugs actually causing numbing, the patient may not realize she's in labor, particularly early on. Then once she is clearly in labor, she may continue to self-medicate with the drug to numb the pain.

Many of these ladies come in very late in the course of labor. Our residents call these the ER to DR admissions — emergency room straight to delivery room. They present in what we call precipitous labor — completely dilated and ready to deliver. This is fairly unusual. Most women realize they're in labor several hours before they deliver. What drugs are associated with precipitous labor? All of them.

Drugs also predispose to fetal distress, which means that the baby is having some difficulty in utero getting enough oxygen. We see on the monitor that his heart rate pattern is abnormal. With respect to cocaine, we know that there are dose-dependent increases in the mother's blood pressure and in uterine vascular resistance as well as a dose-dependent decrease in uterine blood flow. So you've got less blood profusing the uterus, and this then results in fetal hypoxia. It can also lead to problems of the fetus in utero, including hypertension, which can then lead secondarily to stroke.

And the drugs predispose to abruptio placenta — a premature separation of the placenta from the uterus before delivery. Obviously, the baby usually comes out first, with the placenta following 20 or 30 minutes later. But in some of these situations, the placenta and the baby come out at the same time. If the baby is not quite ready to come out and the placenta separates, the baby might die in utero if an emergency cesarian section is not done. If more than 50 percent of the placenta separates, the baby does not have enough oxygen to survive.

Greater Numbers of Undergrown Infants

Almost all the drugs also predispose to *intrauterine growth retardation*. This is when the baby is undergrown. He's malnourished in utero. He comes out looking like a wizened, shriveled-up old man. This is bad because these babies also often have smaller-than-normal brains.

Their tendency to be growth-retarded is obviously related to poor nutrition. Many of these women have no money or very little money. What money they have they use for drugs rather than for eating. So one problem is limited resources. And the drugs themselves, particularly the stimulant drugs, have anorectic effects that take away your appetite. You all know about diet pills that are appetite-suppressing amphetamines. The woman taking these drugs doesn't eat properly because she has no desire to.

But growth retardation is also related to the drug effects themselves. Nicotine, for instance, decreases the uterine blood flow; it constricts the vessels. So do alcohol, cocaine and PCP. They also constrict umbilical blood flow. And the increased incidence of congenital infection and congenital anomolies also predispose for intrauterine growth retardation. As a rule, babies with infections and anomalies tend to be small for gestational age.

Lifestyle Risks of Syphilis, AIDS, Infections

One of the most common *congenital infections* that we see in a group of addicts is syphilis. The incidence of syphilis, which had been going down, is now 40 percent higher than what we saw at the end of World War I. When one has primary or secondary syphilis, 100 percent of the babies will have congenital syphilis. Of those, half will be symptomatic at birth and half will not be.

I think that one of the most important things we can do is to get addicts into prenatal care so that we can screen for the easily treatable disease entities such as syphilis and at least clearly eliminate those. Twelve percent of the addicts at our clinic have syphilis. Early syphilis is associated with an increased risk for abortion and stillbirth if not treated. Just by being able to treat that disease we do a lot of good for the baby.

As I mentioned earlier, a woman who is an addict and poor tends to support her habit by prostitution. And any time you're exposing yourself to multiple partners, the risk for AIDS is ever present. If you have already acquired syphilis, you may have genital lesions. If you're then exposed to the HIV virus, the virus has easy access into your system. And we've seen that any genital ulcerative disease means an increased incidence of HIV acquisition.

Of those women in the U.S. with AIDS, 50 percent are IV drug users and a significant number are also sexual partners of IV drug users. So drug use in women is certainly associated with a higher risk of this disease. And the risk varies, depending on where you live. In the Northeast corridor, among IV drug users in treatment there is a very high prevalence of HIV. In San Francisco it's 13 percent, whereas in Los Angeles it's only five percent. A number of our addicts get on planes and come straight from the Northeast into our hospital. So we have had a number of HIV positive women delivering who are not natives of Los Angeles.

And it is true that most babies with AIDS are born to mothers or fathers who use IV drugs or drugs in general. What is the risk of the child acquiring the HIV virus if the mother is positive? It's somewhere between 40 to 70 percent — a pretty wide range. What I usually say in counseling is that there is a 50 percent chance that the baby will acquire the disease if the mother has the infection. But in counseling we run into an important problem: these women feel that their day-to-day survival is more risky than the ultimate risk of AIDS. They say, "Why should I worry about what's going to happen in 10 years? I could be dead tomorrow, it's so dangerous living on the street." That's hard to argue with because it's true.

Prostitution also puts these patients at risk for a variety of of perinatal infections. These include herpes, genital herpes, hepatitis B, human papilloma virus, genital warts, group B streptococcus, gonorrhea and chlamydia. We need to screen for these infections prior to delivery in order to either treat and eradicate them, alter the route of delivery so that the baby doesn't become infected, or be prepared to immunize the baby at birth.

Other Hazards Caused by the Drugs

Another thing that's been occurring on many of our obstetrical services is that women present with what looks like pre-eclampsia or eclampsia. They

have high blood pressure, and they may have seizures. This happens at the end of pregnancy, just before delivery. We usually treat this disease with a drug called magnesium sulfate. However, we have seen that a number of these women have gone on to die during labor. We're seeing an increase in maternal death rates in this state. That's very alarming and is now being investigated. Some of these deaths are clearly related to drug intoxication.

Cocaine causes vasoconstriction, high blood pressure, and rapid heart rate. It can also cause fatal arrhythmias. So we've begun to suspect that though pre-eclampsia is a fairly common problem in most of our labor services, what we're seeing may not be plain old-fashioned pre-eclampsia, but cocaine intoxication. And that requires different therapeutic intervention.

We also end up doing more cesarian sections in this group of patients because of: 1) an increased incidence of fetal distress, where the baby is not getting enough oxygen during labor and consequently his heart rate changes; 2) premature separation of the placenta from the uterus; 3) malpresentation, where the baby comes out breach or transverse; 4) active herpes; and 5) demand for a second cesarian by mothers who have already had one.

Because they have an increased incidence of vaginal and cervical infections, these women also have a higher incidence of inter-partum infections of the uterus such as amnionitis and endometritis. If they then require a cesarian section, they have a higher incidence of wound infection. So they have a lot more morbidity than normal patients.

Problems of the Infant

Turning our attention to the fetus, we see an increased incidence of *congenital anomolies*. Fetal alcohol syndrome (FAS) is a prime example. It has three major components: 1) intrauterine and postnatal growth retardation; 2) A small brain that works poorly; and 3) facial dysmorphia, or an abnormal face, typically characterized by a flattened mid-face, an abnormally flat philtrum, and a very thin upper lip.

I have here a picture of the brain of an FAS child, and it doesn't take a neuroanatomist to see that this brain is peculiar. Both hemispheres should look alike; they don't. Furthermore, you're supposed to have lots of gyra, or bumps, on the top. The smoother the brain, the more simple the mind — and this one is unusually smooth. It is understandable that these children's average IQ tends to be low — between 65 and 70. The severity of the retardation is correlated with the degree of facial abnormalities. And there is a dose-dependent relationship between those facial abnormalities and the amount of alcohol that the mother consumed early in pregnancy.

Other associated features include heart abnormalities, neonatal irritability and hyperactivity, genital urinary abnormalities, skeletal and muscular abnormalities, eye problems and multiple hemangiomas. Children that don't have the classic features of fetal alcohol syndrome but have some of them are given the diagnosis of fetal alcohol effects.

What about cocaine? Cocaine is associated with an increased incidence of genital-urinary abnormalities, problems with the bladder and kidneys and sometimes with the genitalia and an increased incidence of congenital heart disease. It's been of great interest to me that over the last few years we've seen an ever-increasing incidence of congenital heart disease, documented in studies by the Centers for Disease Control (CDC), and I can't help but wonder how many of these are associated with cocaine.

Babies Born Dying

It's clear that chemically dependent women have an increased incidence of spontaneous abortion associated with all the different drugs, alcohol and cigarettes. And there's an increased incidence of *stillbirth*. Some of this is due to the drugs themselves, particularly the decreased blood supply caused by the variety of drugs we've talked about. And one I'm most concerned about is the newest kid on the block, ice, because the high is so long and one has to be concerned that the vasoconstriction will be long also. With that profound vasoconstriction for a long period of time, there is going to be a significantly increased risk for fetal death in utero. Then of course all the drugs predispose to intrauterine growth retardation. And we already talked about syphilis which is associated with stillbirth as well.

We see an increased incidence of *neonatal death* due to prematurity. Again, 30 percent are delivering prematurely. The drug that predisposes to prematurity more than the others is cocaine. We're seeing a lot of babies coming out at 25, 26, or 27 weeks,

with increased problems in the neonatal intensive care unit. Some of them die in the neonatal period due to infections or anomalies. And some deaths are associated with birth asphyxia.

Finally there is an increased incidence of sudden infant death syndrome (SIDS). Opiate-exposed infants have an 11-fold increased incidence of SIDS; with cocaine there's about a 20-fold increase. So if the babies make it beyond the newborn period, that is, the first 28 days of life, they're still at risk of dying from SIDS.

Now, this is CDC data from 1986: the three leading causes of infant mortality in the U.S. are now birth defects, low birth weight and prematurity, and SIDS. Do you think it's surprising that these are very common complications of drug use during pregnancy? I think not. We can see that the contribution of birth defects to the infant death rate has been increasing. And I think that we have to be concerned about the impact of the variety of drugs being used now on this statistic.

Crises Faced by the Newborn Who Survives

The babies tend to go through neonatal withdrawal. The absolute pattern of withdrawal in the nursery varies from drug to drug, but let's be lumpers instead of splitters. What's the worst withdrawal syndrome? Probably the one we see with PCP and methadone withdrawal. You have a baby who is never still, who screams continuously. The next most severe would be opiates, then cocaine.

Some authorities thought at the beginning that cocaine babies didn't go through withdrawal. But these babies, just like their mothers, go to sleep when they come down from their drug. They're very sleepy and lethargic; it's hard to wake them up. Gradually they start coming out of it, and usually around six weeks they really wake up. Then you've got to peel them off the ceiling, because they're very, very hyperactive.

So at the beginning we thought they didn't have much in terms of symptomatology. But as we continue to observe and observe more carefully, we see that they do have symptoms, but these symptoms are slightly different in character and timing from those of other drugs. How long does drug withdrawal last? That again varies from drug to drug, but with PCP, for example, it often lasts several months.

Chasnoff has demonstrated that cocaine-exposed babies in general tend to be more fragile, easily overloaded and unable to process and modulate stimuli. They move abruptly from state to state, which is not normal. They go from dead sleeping to screaming awake and then back again — clearly not what a baby is supposed to do. I'm getting into an area that I an not an expert in; I catch them and pass them on like a quarterback. But I would like to comment on one thing.

We're talking about a baby who is biologically vulnerable because he's been drug exposed in utero. He may have a lot of medical problems. He may be a preterm baby and may have some birth defects. He's also going through drug withdrawal. So he's a very difficult child for the best of us to take care of. You give that difficult baby to a mother who's got her own set of problems and doesn't know how to take care of any baby, let alone this baby, and I think you have a real set-up for problems. Dr. Barry Zuckerman of Boston City Hospital calls that double jeopardy. I agree. That's clearly what's faced by this group of kids.

Characteristics of the Mothers

Though the Pinellas County data clearly shows that not all chemically dependent pregnant women are poor, I only take care of poor patients. They're also predominantly from minority racial and ethnic groups. So I have a skewed view of the world. My patients tend to be poorly educated; many haven't finished above the 9th grade. They're all born in America though, so they're all citizens, which is different from the rest of my obstetrical population.

They tend to be unemployed. These women are often single parents with other dependent children that they're responsible for. They have very low self-esteem and feelings of worthlessness and learned helplessness, which means they don't really think that they can make choices that will alter the course of their lives. That's very different from the rest of us, who think that we can make decisions and plan for tomorrow. These women haven't been able to plan for tomorrow since the day they were born. They've just been sort of riding the wave and trying to stay alive.

They often come from very dysfunctional families. Most of them have a parent who is either an alcoholic or a drug addict. Many of these women

have fetal alcohol effects. Many of them were drug exposed in utero themselves, and then raised in that dysfunctional environment. Many have a family history of mental disturbances, and we're seeing a number of them with dual diagnoses, that is, they have a real mental disease in addition to their drug use. Unless we treat both problems, we will not be successful.

Many of them have been physically abused or battered in childhood. Seventy-five percent experienced sexual abuse in their childhood. Many ended up as runaways or as throwaways living on our streets. So it's perfectly understandable, I think, that these women are going to have trouble raising a child, and they're going to have even more trouble raising a difficult child with special needs. They lack social support. They can't turn the baby over to grandma or to auntie for a few hours to get a break. There is no one to help them.

The Harbor Hospital Program

In 1986 we established a prenatal clinic at Harbor for these women, and it now also includes an infant follow-up program. I think the components of such a program need to be assembled as much as possible in a one-stop shopping arrangement. We provide prenatal care; pediatric follow-up which includes well child care and immunizations; developmental testing of the child to identify any problems and to get treatment initiated if necessary; social service case management based on an individual treatment plan developed for each patient; drug treatment on site which includes individual, family and group counseling; and parenting classes. This last is really critical because these women have never had a good parenting model. They can't rely on saying, "What would my mom have done in this situation?" Their moms would probably would have beaten the bejeebers out of the kid.

We have support groups. All the self-help groups need to be brought in, from AA to CA, NA, and Al-Anon. Home visits will be started soon, as will childcare. We need to have a drop-in center so that clients who are on the fringe and want to check us out to see if we're good guys can come by and experience a day in the program before signing on for the full ticket.

You also need to have an ability to do crisis management, either a hot line or, as we have, a warm line which they can call for messages on a daily basis. We do lots of community outreach. We're going to be providing transportation to the site with bus passes. We also need to train other professionals and — very importantly — we need to provide family planning.

Benefits for Mothers and Infants

Let me summarize the outcome differences in patients who come to us prenatally versus those who are only identified at the point of delivery. Eighty percent of our babies are born drug free at delivery. There is a significantly decreased incidence of prematurity, low birth weight, and low Apgar scores; fewer of the babies require neonatal intensive care unit stays; they have shorter hospital stays; and more of them go home after the usual three-day stays — because they're healthy. There are fewer deaths and less syphilis. And fewer require foster care placement. In fact, over 60 percent are going home with the mother, and because of this there is also less involvement with the Department of Children's Services and the courts.

We're looking forward in the not too distant future to expanding our drug treatment program with monies obtained from the governor's budget. We'll have more specific discussion groups, vocational/educational counseling referral, life skills development and health/fitness/nutrition education. We'll continue AIDS education, alcohol and drug education, self-help groups, child development and parenting classes and development assessments. We'll be able to add a childcare facility with a therapeutic nursery. And we'll continue to do random screening and coordinate prenatal and postnatal care. The women will have social and recreational activities. And we'll be providing transportation and lunch. So it will be something, if we ever get it off the ground.

All of us at this conference have a responsibility to make sure that children born to addicts have a life of substance rather than a life of substance abuse. We know that they face a significantly increased risk of becoming addicts themselves if no intervention is done. But with intervention, these children and their mothers will recover and lead successful lives.

Providing Continuous and Comprehensive Services

*Pediatrician **Neal Halfon** is Director of the Center for the Vulnerable Child at Oakland Children's Hospital. The Center houses several programs serving drug-exposed children and their families. Dr. Halfon is also an Assistant Professor of Pediatrics and Health Policy at the University of California at San Francisco.*

I should start off by saying that there is a certain personal irony with my being up here today. Three years ago when we were starting the Center for the Vulnerable Child at Children's Hospital I had a very different perspective on the problems of drug-exposed babies and chemically dependent women. At that time I thought that all drug affected babies of chemically dependent mothers should be taken away from their mothers at birth and placed in foster care. Only after I had contact with such people as Nika St. Claire, Barbara Tittle and others at our hospital did I come to realize that much can be done for this population and that we need to look around to see what was already being done and what kinds of treatments could be marshalled.

Today I'm going to give you an overview of the research and policy agenda around this issue — the kinds of questions we need to be asking and the kinds of models we should be developing. I think that the data we are familiar with at the present time — from Dr. Ira Chasnoff, Dr. Margaret Yonekura, Dr. Xylina Bean — is that early interventions and treatments do seem to work with chemically dependent pregnant women, decreasing morbidity both to themselves and to their children. I think that the really difficult questions facing us have to do with the kind of research that needs to be done and the kinds of programs that need to be developed.

We're not talking about putting together high-intensity, thoroughly comprehensive model programs that offer a full continuum of care for 10 or 15 women. Since this problem of chemical dependency is increasing, we need intensive programs for larger numbers than we had ever expected. And in the current policy environment, the level of resources needed to create such large programs will be difficult to come by. We must have research that allows policymakers to look at the costs and benefits involved. So what I want to do today is provide some framework for the needed research by giving an overview of the nature of the problem.

"We're looking at incredible amounts of dysfunction and disability. A small program for only part of the problem is not going to be effective."

Needed: A Continuum of Care

I'm going to talk about a continuum of care for chemically dependent women and their drug-exposed babies. The reason why a continuum of care needs to be created is because chemical dependency is a disease. We're looking at incredible amounts of dysfunction and disability. A small program for only part of the problem is not going to be effective. Instead, we have to have services that really span the entire array of problems. This calls for a continuum of linked services that provide every step necessary in the whole process. That's very, very difficult for our society to do from a public policy standpoint.

The problem involves turf issues — among social service, health, and welfare agencies. And it involves the way we organize services, which I'll talk more about a little later. We don't have very many models for a continuum of care in our society. One

of the only good models that I know in health care is a program here in San Francisco called On Lok that provides comprehensive, continuous services for the frail elderly. It provides all kinds of services, not just health, but social welfare services across a wide spectrum of needs for this population. On Lok doesn't exist by happenstance. There's been a lot of research and a lot of lobbying and a lot of pressure that's come down on the side of the elderly and their health care program needs. And I think we need to look at those kinds of models and say how are they applicable for the population that we're concerned with here.

What does continuous, comprehensive services for mothers and children mean? I have a chart here that can serve as a model. Let's look first at the child's end of things. Down the side we have listed prevention, early identification, diagnosis, treatment and rehabilitation. Across the top are the domains of physical, emotional and cognitive development, then family, social and peer relationships. When approaching care for a child, either in our foster care clinic or in our drug-exposed baby clinic, we try to use this matrix to define the range of needs that this child has. As we see these kids in foster care or with their biological parents, we can identify specific needs in each one of these categories .

The problem comes after we do this very comprehensive assessment. We see what kinds of prevention services they need in the emotional domain, what kinds of early identification things they need in the cognitive domain, what kinds of rehabilitation services they need in terms of their families. We can make an incredible laundry list and show exactly what needs to happen. But when we want to get services, we're faced with a vast array of different public programs that are often in different buildings and different areas around town.

So a foster mother who has four or five foster children in her home, many of whom are drug-exposed and need a variety of services, has a very difficult time getting all those things unless she has a one-on-one case manager. The same holds true for a chemically dependent woman who is having a hard time making ends meet and is trying to get reorganized in terms of her baby. She has to go all around town to get all the kinds of services she needs.

In other words, what we've created from a policy standpoint is a system that's not very user-friendly.

Existing Comprehensive Efforts: Common Goals and Problems

Wendy Jameson at our Center for the Vulnerable Child has taken a look at a variety of programs around the country that are attempting to provide comprehensive services. These include programs from New York, Philadelphia, Los Angeles, San Francisco and Oakland. We surveyed these programs and looked at the number of clients they had, the kinds of services they provide, and tried to get some sense of what they were doing. Of the 10 programs surveyed, the common goals were to decrease maternal drug use, reduce the barriers to needed services, promote family reunification and utilize an ecological approach — that is, focus on the individual mother and baby, the family and environmental interventions.

All of these programs have similar clientele — mostly minority women and children. They are poor, inner-city inhabitants. The mothers primarily use crack cocaine. They have a history of physical or sexual abuse and of parental drug and alcohol use. The programs all emphasize the same kinds of services. They were all trying to provide a continuum of care, from the prenatal period through the child's early years. They were all trying to provide a wide range of services — medical, psychosocial and practical support services — from that whole range of public programs that I mentioned earlier. And they were emphasizing case management, with similar roles and activities for case managers across programs. The case managers serve as the glue to try to pull all this stuff together for each client.

I think it's very important that they all emphasized not just the medical but the psychosocial and developmental needs of these women. Even though many of these programs are being provided in health care settings, and we like to talk about the fact that chemical dependency is a disease, we have to realize that it has very strong root causes in social pathology and in long-term dysfunctional relationships. One of my big worries is overmedicalizing this. As a physician, I know that we don't do a great deal of good when we overmedicalize things. So I think that these programs' emphasis on psychosocial and developmental interventions is appropriate. But it is difficult, given that the financing generally isn't supporting that.

The other thing that all the programs seem to be emphasizing is interagency coordination and regular

interagency meetings. This whole integration/ coordination thing has become like oat bran — everybody's calling for it, and we all think that it's good. But we have no idea actually how to do it. When we get into a room together, other kinds of forces seem to prevail.

Another difficulty is the incredible dearth of program evaluation. The programs for the most part are too new to know what the results are and how effective they are. Some have put a minimal amount of effort into evaluating what they're doing, but not much. And in fact there are some very common obstacles to these programs' effectiveness. For example, they have great difficulty recruiting and retaining good staff. People have not been trained to do this kind of work. There's a major training and education need which is an important policy issue at the present time. Moreover, there is difficulty finding long-term funding and funding for specific needs for such facilities because the funding streams run along direct service lines. You can't get funding for the full complement of services unless you're very, very skillful. Or you get a big grant that lasts two years and then you're out of dough.

Other problems include the lack of community infrastructure to serve client needs. Even though you might have a nice program, things like housing, transportation and residential drug treatment that are needed to support your clients are non-existent in the community or difficult to integrate with your program. And there is also a lack of knowledge on how best to improve outcomes for chemically dependent women. People are getting in there because of the urgency of the problem, but often the true efficacy of specific models or combinations of services has not been worked out. Lastly — and this is certainly not big news — there are problems with health and social service delivery assistance and covering the kinds of gaps that exist in the system.

A Wish List for the Ideal Program

At our center, we've been using this information as a way of answering the question, "What would be a model program?" In an ideal world, chemically dependent women and their children would get a continuum of care covering their needs from soup to nuts. Their needs can be delineated in three areas: prenatal, perinatal and postnatal services. The types of prenatal services that need to exist are outreach to pregnant women and comprehensive prenatal care that includes residential treatment, housing, education, job training and drug treatment. All of this happens before women deliver their babies. Now very few places in the country are able to offer this full composition of services. In addition, case management which goes across this whole continuum needs to be provided.

The perinatal area — when they deliver their babies — involves a whole other set of services. These include pediatric and obstetric services and an intensive amount of social support and coordination within the hospital if these babies are going to be able to go home with their mothers in any kind of reasonable way and be ensured some kind of ongoing follow-up. In addition, the set of services for biological families must include medical, developmental and emotional assessments for the baby and medical care and psychological treatment for the mothers. If you're going to put them back on their feet you must also have chemical dependency treatment, case management, family support services, housing, education and job training. This whole set of services has rarely been put together in one place at one time, but it needs to be done in some shape or form.

Unfortunately, a certain number of the kids are going to go into foster care. And those kids also need comprehensive assessments, along with a comprehensive set of treatments, including medical, developmental, emotional — going back to my original matrix of what comprehensiveness means — along with case management, family support and social service liaisons.

Now one of the key elements of this model that I'm presenting is the postnatal component, which I don't think exists anywhere in the country. I'm talking about a family support center. The idea is that if babies have to go into foster care for some period of time, they shouldn't be going in for 18 months, 36 months or three or four years with very little contact with their mothers and then be in a situation of trying to reunify with her. The contact between mothers and babies needs to be maintained right from the very beginning if that mother is going to have any chance of forming any kind of meaningful relationship with that baby over time.

What we have now sets up very adversarial kinds of relationships between foster parents and chemically dependent women. There's a lot of castigation and

judgment. So the idea is to set up some kind of support center that allows the foster parents to be used as therapeutic agents in terms of reunifying babies with mothers. Mothers can come to a non-threatening, supportive environment in which they can be helped and supported to develop relationships with their babies. In this kind of setting, you would also have a child development-oriented, therapeutic nursery for respite services for the mother who takes her baby home but needs additional support. And you would include infant-parent and home visit services.

Getting There:
Making the Bottom-Line Arguments

I think that at the present time we have a very weighty task in front of us. The research that we have available to guide us is very sparse. Research looking at the long-term outcomes of kids either going to their biological homes or going into foster homes is basically non-existent. It's been done on small samples with very few controls. And we have very little information about what truly works. If we're going to wade into the policy arena, we urgently need research to show us what level of services need to be provided, how the different pieces in a continuum like the one I've described actually go into a unified program, and whether or not those kind of services can make a difference.

We don't really know this at the present time. A lot of us who work in this area feel that they do make a difference. But we have to be able to prove it, both in terms of short- and long-term outcomes and in terms of bottom line issues. We have to be able to show that if we provide comprehensive prenatal services or family support services, those are going to save dollars down the road. And that's something that will be very tough to do.

Stretching Resources to Reach Increasing Numbers of Families

*Pediatrician **Xylina Bean**, an Associate Professor of Pediatrics at UCLA, directs programs serving pregnant addicts and drug-exposed young children and families at King-Drew Medical Center in Los Angeles. Dr. Bean has many years' experience providing innovative interventions to hundreds of drug-exposed families.*

Basically, I am going to talk about the programs we have. If I hold these up against the backdrop Neal Halfon has just given about programs that should exist, you will see that: 1) We can do something, even in context of quite limited resources; and 2) We have a whole long way to go.

I have been involved in this particular issue for many years. The interesting phenomenon for me is that everybody else has suddenly gotten interested in it. I don't know what that means for the overall future. It's nice, but I'm not exactly sure yet where it's going to lead.

Whose Problem Is It?

I come to this work with a significant historical perspective. I was introduced to perinatal substance abuse as a medical student at the University of Pennsylvania. There I met Loretta Finnegan of Jefferson Medical College, one of the mothers of perinatal substance abuse intervention. Dr. Finnegan has run a program for many years, working primarily with heroin-using mothers. So I got introduced to her methadone model for providing services to substance-abusing women. And when I came to California, lo and behold, I was an expert on a subject that nobody else seemed to know very much about.

The methadone model had shown us that it was possible to intervene effectively with this population. And it had documented very clearly many of the essential components of intervention. If you were dealing with pregnant women, you had to link medical care, prenatal care and drug treatment. The model even showed us the necessity for dealing with the children, providing childcare and transportation. So the model was very well described in the context of heroin and methadone.

"We're writing legislation as if cocaine is somehow unique and is going to be unique forever. That's a ridiculous approach to drug policy."

But for some reason, this society had made a decision that we had solved the problem. We decided that heroin abuse was a limited problem, relegated to small group of hard-core addicts who lived in inner cities, and it had very little impact on society. We had basically thrown away our children. And we lived with that. It was perfectly acceptable. Society as a whole had dealt with that problem by saying: 1) It wasn't much of a problem — it didn't really affect the majority of us; and 2) We had methadone, so if these addicts wanted treatment, they could go and get it.

Dr. Finnegan and a small cadre of very dedicated people spent years of their lives trying to work with this population, but very little interest was expressed by anybody else. In the 1980s in Los Angeles we suddenly had a PCP epidemic. Well, as long as the epidemic was relegated to south-central Los Angeles, nobody cared. I couldn't get a lick of money from nobody to do nothin'. Nobody wanted PCP abusers in their treatment programs, and nobody was going to fund anything to take care of them. Because again, this was a problem relegated to south-central Los Angeles, and crazy black folks running around south-central Los Angeles do not affect the rest of us.

Then finally, we got cocaine. The nice thing about cocaîne is that we in the general society have decided that maybe this is a problem that actually will affect us. I am a strong believer in the trickle-down phenomenon. Hopefully, some of that realization, some of that concern people have about their own children, their own families, will trickle down and I will get some benefits in south-central Los Angeles with the families that we are struggling to work with. I haven't seen a lot trickle down yet, but I'm hoping it eventually will get there.

Meeting Vast Needs in South-Central Los Angeles

In 1986 the household survey done by the National Institute of Drug Abuse estimated that three million people in the U.S. use cocaine regularly — which is about five times the number addicted to heroin. The interesting phenomenon was that 15 percent of the U.S. population as a whole had tried cocaine, and 40 percent were in the age range of 25 to 30. Assuming that about half of these people are women, this affects a large number of women of childbearing age and a lot of kids. It's estimated that in the U.S. we get a minimum of 365,000 children per year who are born drug-exposed. In California then, since we get one out of every 10 births, that's about 36,000 babies.

When we came to look at this population in south-central Los Angeles, we also realized that any models we created had to be able to serve large numbers and to make some kind of impact in terms of the community as a whole. I actually started by trying to duplicate a model that had already been around for a long time — a residential program for women and children. It's a perfectly logical approach, and we based a program on it.

The problem was that when we managed to duplicate that model in 1985 it served 20 women; in 1989 it still serves 20 women. For all of south-central Los Angeles, ours was the only program. It became clear that though this was a very good model — one version of it is the Mandela House — it was not one we could continue to use because we had already put about $1 million into it, and we didn't have the money to expand it. So we decided that this model was not going to be the way to go.

Realizing that some intervention was better than no intervention, we started a series of programs that would serve more people. Again we looked at other models, but I didn't entirely like them because they separated women from children. With a finite amount of money, that tended to cause fighting over who got what: How much should go to the mothers? How much to the babies?

Vital Services With No Strings, No Fee

So I developed at King a program called **Project Support**. I would give no money to pediatrics and no money to obstetrics. Instead I developed a group of people whose basic job was to work with mothers and provide the same services to them whether they came in pregnant or not pregnant. We tried to target pregnant women because, again, the money flows to programs that target them. The realities are, we have not been very successful in doing that. And when I talk a little later about the governor's budget change proposal, I will talk about some of the things we're going to try to do to rectify that.

The idea is that we made these services available to the obstetrical services which were providing the prenatal care and to the pediatric services which were providing the follow-up. We started out just aiming to help these people. We figured we would get mom into a drug treatment program, and then we would be finished because the problem would be solved. But we very quickly discovered that there were no drug treatment programs that we could get them into. So Project Support — which started out providing services primarily to mothers during pregnancy and right after delivery and then helping them deal with their babies and with the Department of Children's Service (DCS) — had to be expanded.

We said, "We still want to get you into a drug treatment program. But while you're waiting, we'll provide you with counseling services and as much intervention as we can." Project Support staff consists of a social worker, a public health nurse, and a community worker. We initially did intake, interviews and health education. Then we wound up doing group counseling. Then we discovered a whole bunch of folks had real serious problems. So we developed a relationship with psychiatry, and we do individual counseling, family counseling, parent education, crisis intervention and home visits. Equally important for these women, we do urine testing. And it's all free.

That's major. It may not seem like such a big thing. But here you have a population with extraordinarily

little money and resources. Being free made us one of the most popular programs in Los Angeles. At this point we turn people away, which is hard.

Since we started Project Support in 1987 we have had interaction with 360 clients, including long-term interaction with about 100 women. Our primary focus is family reunification. We work on a long-term basis only with women who get custody of the child or whose child goes to the home of a family member where the mother remains the primary caretaker or is frequently involved with the child. It isn't that we think foster care is not important. But you have to target a population, and we identified this population as one at extremely high risk and not getting adequate resources.

Beyond Drug Free: Programs to Foster a New Life

The kind of intervention that many of these women needed was a lot more intensive than what we were providing in Project Support. There were a number of women who wanted to make a fundamental change in their lives. So for them we created the **Eden Development Center**. There you have to be willing to commit to a five-day-a-week, center-based and home-based program for up to three years. And we expect you to come. This program doesn't just deal with the fact that you're going to become drug free. It attempts to change your life. That may mean changing where you live. It definitely includes changing your attitudes — towards your life, your children, your community, your responsibilities. We make you go to PTA meetings. Because these are the kinds of things that you have to do to change your life.

The **Children's A.R.K. Project** (Assistance and Relief for Kids) is different from the others in that it is sort of your last chance. The women in this project are referred by DCS — the family has gotten to the point where DCS is considering taking the child away. We will take you as an out-patient for 90 days, care for your child in our crisis intervention nursery, and try to help you make changes — or else DCS is going to take that child. And we're starting something new, the **HERO Program** (High Energy Resources and Opportunity), which will be prevention-oriented and work with groups of nine-to-15-year-old siblings of the drug exposed babies in our other programs. These kids are one of the highest risk populations.

Legislative and Policy Myopia

The governor vetoed Jackie Speier's bill, but he gave us five pilot projects. In California, we separate drugs and alcohol. Money for drugs goes here, money for alcohol goes there, and trying to get those things put together again under the governor's budget change proposal is almost impossible. The state's policies tend to be drug-specific, which is stupid. The next drug of choice is going to be amphetamines, everybody knows that. In the Fifties we had heroin, in the Sixties we had LSD, in the Eighties we got PCP. Now we got cocaine, and next we're going to get amphetamines.

But we're writing legislation as if cocaine is somehow unique and is going to be unique forever. That's a ridiculous approach to drug policy. And we're still writing proposals and passing legislation that separates out treatment for women and children. Children are an afterthought. Even in this so-called pilot project, children are an afterthought. We have to figure out a method of providing services for the children while supposedly buying treatment for the mother.

Before I close, I'll just mention that we do work extensively in all of our programs with issues related to foster care or extended family members. One of the things we're hoping to do with the day treatment program is act as a stimulus to encourage community agencies to use that program as a mechanism to create some things we need, such as extended-family support groups and foster-care support groups.

Ethical Dilemmas and Public Policy

*Attorney **David Chavkin** is the Director of Public Policy for the National Center for Clinical Infant Programs in Washington, D.C. He is working with the National Coalition on Drug Dependent Women and Their Children to develop a comprehensive agenda for legislators.*

I am going to give you a flavor of what's going on in Washington, partly focusing on the outcomes but also giving you a sense of the process that's getting us there. Before I turn to that, there was something that struck me about Neal's presentation. Neal commented about looking towards elderly programs. In another one of my lives, I sit on the National Advisory Panel on Alzheimer's Disease and Related Disorders. We look at the On Lok system, which is a wonderful system — if you haven't looked at it, you ought to. The trouble is, we've had lots of problems replicating it. What we say in the elderly system is, "Gee, what can we learn from the great way the children's service system is operating to help the elderly?" So we can learn from both sides, but the grass often looks greener on the other side.

Potomac Overview

In looking at the Washington process and what's going on nationally, there are three maxims that you can keep in mind. The first is that you will never lose money underestimating the collective intelligence of Congress. The second is that there are two kinds of people in the world — one group who believe that everything important happens inside the Beltway, and another who know that nothing important happens there. The third maxim is an extension of Andy Warhol's notion that everybody will get 15 minutes of fame. Every issue gets 15 minutes of attention in Washington, and we have used 10 of the 15 minutes already for concerns about services for drug-addicted and other substance-abusing pregnant women and their children.

In looking at the current debate, there are two factors that have absolutely structured that debate. The first is the whole issue of the incidence of crack-addicted babies. Xylina talked about the importance of crack in getting people to focus, and that is absolutely correct. It is barely an overstatement to say that nobody in Congress cares about heroin abuse or amphetamine abuse or PCP abuse. And it's hardly more of an overstatement to say that nobody cares about fetal alcohol syndrome, despite the ravages on the Native American population.

"You cannot make sense of the current public policy debate without understanding the whole issue of abortion."

They like crack. Not a small amount of that is they like the word **crack**. If you ever saw the film *The Sunshine Boys*, they talked about how some words are funny. Pickle is a funny word, it's got nice consonants in it. Crack is exactly the same way. Congressmen like to say crack, and that's in fact colored the treatment of the whole debate. I don't want to be too cynical about this, but I want to give you a little bit of insight.

Ties to the Abortion Debate

You cannot make any sense of the current public policy debate without understanding the whole issue of abortion. That's not always easy to do because the "a" word is not discussed very much by either group in the context of the debate over services.

On the anti-choice side, if life begins at conception, then the administration of a substance dangerous to

the pre-born human being — that's using their term — obviously is battery or child abuse or, depending on the outcome for the fetus, homicide. This viewpoint, unfortunately, poses a couple of problems even for the anti-choice group and their potential allies. First is the problem of overbreadth, because you can have a negative impact on the pre-born not from just illegal drugs, but from lots of legal activities like smoking and failing to use a seatbelt.

The other problem is the growing recognition that if you have a certainty of criminal prosecution for someone who is abusing substances and is pregnant, that's going to effectively compel the pregnant woman to seek an abortion as a way of avoiding prosecution. That's exactly the outcome they say they don't want, but they're talking about an almost absolute method of pre-empting choice. So that group has been focusing largely on fault on the part of the mother. And it's not just anti-choice people, it includes some pro-choice people.

On the pro-choice side, the argument for pre-emption of government regulation is founded on the principle that the fetus has no rights until birth, and therefore the woman can't be prosecuted for child abuse or other activities because there's no child in being to bring within the protection of the law. That's got some problems also in the context of this debate. Even in *Roe v. Wade*, as you know, in the third trimester or at least at the point of viability the child begins having some due process rights under the law, and/or — depending on how you formulate it — the government has a right, a compelling interest, in preserving life and interfering with the decision-making process. So that's a problem already. You can already constitutionally punish for harmful conduct toward the fetus during the last trimester.

The second problem on the pro-choice side is that the possession of drugs is already a criminal offense. So when we talk about not wanting to criminalize this conduct — it's already criminal. The real question is more a matter of singling out pregnant women for prosecution.

And a third element is that you're talking about women who either actively or by default decided not to exercise their right to have an abortion. That also raises the issue of fetal rights to a whole different level.

Just to give you a sense of how the debate on the pro-choice side is focusing, Ellen Goodman recently wrote a piece in which she warned those who talk of fetal rights that the government could constrain a pregnant woman's diet or physical activity, stamp out her cigarettes, and empty her wine glass. In a different piece, Alan Dershowitz, professor at Harvard Law School and a rather well-known civil libertarian, rejected her argument and said that some protections must exist against maternal excesses that threaten to cause enduring damage.

A Middle Ground Coalition

So there are two admittedly very vocal extremes. The question is, what's going to happen in the middle? In the middle we've got people from both sides, and the new National Coalition on Alcohol and Drug Dependent Women and Their Children tries to bring them together. The coalition was formed in response to a number of things happening at the Washington level. The first was a whole series of hearings and reports. The House Select Committee on Children, Youth and Families had a hearing in April. They released a survey about the increasing incidence of drug-exposed births. Then there were the NAPARE (National Association of Perinatal Addiction Research and Education) Survey, the Senate Labor/Human Resources Committee hearings and the Senate Governmental Affairs Committee hearings.

The second big impetus was the cases. There are basically three cases now that have people's attention. The first was the Elizabeth Levy case in Massachusetts, which was just recently resolved. A woman who had had five gin and tonics drove a car into a pole, her eight-and-a-half month fetus died, and she was charged with negligent homicide. She just recently pled guilty to drunk driving, in part because there are real problems of proof in terms of showing what had actually caused the death of the fetus.

The second major case was the Jennifer Johnson case. She was tried in Florida of criminally conveying drugs to a minor because she took cocaine and passed it on to her unborn child. She was convicted; that case is now on appeal. The third case is the Melanie Greene case from Illinois. An Illinois Grand Jury refused to indict her for involuntary manslaughter after the death of her unborn child.

Another factor that has colored this debate is the introduction of some legislation that has made people very crazy. Two pieces come immediately to mind. The first is Pete Wilson's bill, S1444, which was proposed as the Child Abuse During Pregnancy Prevention Act of 1989. The main problem is that although it proposed to set up model projects, it also included the words "and for other purposes." The other purposes were the problem. The bill had five troublesome elements: mandatory reporting by health care providers; a requirement that child abuse laws be amended to specifically treat as child abuse giving birth to an infant who is addicted or otherwise injured or impaired; three years mandatory rehabilitation in a custodial setting for violation of the provisions; and expedited adjudications — a rush to judgment. The bill covered both legal and illegal substances.

The other big bill was S1409 by Malcolm Wallop from Wyoming which provided for mandatory drug testing for all applicants for governmental assistance programs, primarily AFDC.

The Issue:
Not Whose Rights Are Violated But What Works

Those congressional aspects along with certain state developments — especially introduction of bills ranging from mandatory sterilization to amendment of child abuse and neglect statutes — sort of forced a lot of groups to form this coalition. They range from the ACLU and the National Women's Law Center on one side of the political spectrum to a variety of child welfare and prosecution groups on the other. What we've tried to do is come up with a formulation to influence the thinking in Congress about this process. Basically, there's an Ellen Goodman formulation that some of us have tried to use after talking to a variety of people providing services to this population.

She wrote: "When those who work in the fallout of the drug world talk about mothers and babies, the issue is not whose rights are violated but what works." Now in fact, we think that's a little bit of an overstatement because it's true that the first focus is on what works, but if you want to do that in an effective way you have to focus on whose rights are violated. In part what that means is to focus on issues of selective prosecution of poor women when we know that in fact this crosses socioeconomic lines and that in fact there is culpability of men as well.

Anyway, the coalition basically formed around a continuum of governmental intrusion in an attempt to improve outcomes for mothers and infants. We have two areas of focus. First, there is the whole question about the extent to which success is really linked to voluntary as opposed to mandatory utilization of services. Neal talked a bit about research issues. Well, this is one issue that desperately needs research in the policy debate. A variety of people have talked about how you get better outcomes with voluntary programs. But frankly, there is very little empirical evidence on that. If people are working on that, we need to know about it in order to buttress our efforts.

The other focus is that we don't favor using criminal child abuse statutes and criminal prosecutions generally.

Legislation in the Works

But let me jump ahead and focus a little bit on what's happening in terms of actual legislation. Most of you know the primary vehicle for the president's national drug strategy is the 1990 Department of Transportation appropriations bill. You might wonder why the national drug strategy is in the transportation appropriations bill, but explaining that would require a little bit more time than we have today.

The president requested $2.1 billion in additional funds with a 73-27 split between supply reduction and demand reduction. When the law was enacted it actually provided $3.2 billion, an increase of $1.1 billion over the president's request, and a 69-31 split, getting a little closer to the [illegible] split that most of us were hoping for. It is an appropriations bill, which means that you still have to have authorizing legislation. But the major features of it are a $415 million increase for the Alcohol and Mental Health Services (ADMS) block grant. In Washington, $415 million is small change, but we hope it's going to make a significant difference in terms of funding some of the programs represented here.

That brings the block grant up to about $1.2 billion, because there was an increase already in effect in the Labor/ Department of Health and Human Services appropriation which the transportation bill added onto. It's a very confusing process, but that's the way it worked. There were other increases, including money for the waiting period

reduction grant program — an additional $40 million. There were Office of Substance Abuse Prevention (OSAP) increases in there. Of main concern, I think, is the additional $45 million for prevention grants, of which $25 million is to go for treatment, including residential treatment, of pregnant and postpartum women and their infants. In addition, the Labor/HHS bill had $57.8 million, of which $15 million was earmarked for that purpose. So it's a very, very substantial increase in the amount of funds actually appropriated for treatment.

Appropriations bills only go so far; you have to then go and pass some legislation to authorize that the money be spent. That process has not been completed. There are two bills — S1735 in the Senate, and HR3630, which is Waxman's bill, in the House. They're meeting in conference and have most of the issues resolved, but not everything. In any event, what the conference bill does is retain the basic structure of the ADMS block grant which the House had proposed to significantly gut. But it does provide now for taking money out of the block grant and making some categorical grant programs for prevention and treatment for this population.

Probably the major change is that the OSAP program of projects for reducing the incidence of alcohol and drug abuse among pre- and postpartum women will be authorized starting in 1991 at a level of $100 million. So we're now getting to the point, as Everett Dirksen would say, of actual money.

Finally, there's another bill that's pending right now — S1711, the Biden-Hatch Bill — which would provide some broader changes in the drug implementation strategy. Because you've got a bunch of different bills happening at the same time, there are pieces of each bill in the others. So depending on which is passed first and signed first, there will be some changes in the later bill. But the highlights of this bill are the creation of a national resource and information center for perinatal addiction, additional training grants, additional substance abuse treatment monies, an emergency child protective services grant, and a primary pediatric care grant for disadvantaged children.

New Medicaid Changes Bring Hope

Some of these things are very categorical and very scattered, as Neal mentioned. In thinking about how you pull together monies, you should not lose sight of the changes recently made in the Medicaid statute. There are new requirements in three major areas: 1) There were enormous and very fundamental changes made in terms of expansion of eligibility. This is going to have impact even in states that have relatively generous programs like California; 2) There are changes in the services that are covered under the EPSTD (Early Periodic Screening Diagnostics Treatment) program. One of the big changes is that services are now mandated so long as they are medically necessary, regardless of whether or not they are covered in the state plan. That means that any service determined necessary as a result of a screen, that can fit within the context of a medical service, is now a mandatory service independent of any amount, duration or scope requirements that apply under the state plan; and 3) Now, for the first time, the Medicaid statute requires access to services for poor people on Medicaid at least equivalent to those enjoyed by the general population.

So those of you who are dying with Medicaid reimbursement levels that are far too low to provide services can see some real hope for expansion of funding. I'm sure it's going to involve litigation in California. But it's something you want to keep in mind. All of these changes will be effective April 1, 1990.

Generations At Risk to the Nightmare of Addiction

***Gina Barclay-McLaughlin**, Founding Director for the Center for the Successful Child Development ("The Beethoven Project") in Chicago, has worked in child development and education for 25 years. She is currently a national consultant in early intervention.*

First I want to say to all of you that your presence here shows your commitment to grow in knowledge and understanding of a problem I feel we should all embrace. To address this problem of addiction, we have to make some major changes in our society and our world. Your role is extremely crucial in that process. I feel a sense of responsibility to work on the problem of addiction. But I also have a mandate from my program to generate around the country a commitment to changing life. We must make sure that we don't just deal with the right to life, but with the right to quality of life.

The Beethoven Project: Successful Child Development

Our program is about early childhood intervention. Its official name is the Center for Successful Child Development (CSCD), and we're located in the Robert Taylor homes, the largest public housing project in the United States and one of the most impoverished. We believe that early childhood intervention effectively combats the high risk of poverty. And that philosophy is now in the forefront of new public policy. We're unique in our services to all infants and mothers. We try to strengthen the caregiving relationship in order to foster the development of young children living in poverty. And we work to increase understanding of life in the Robert Taylor community.

The program is operated in 12 of the apartments. I believed that our residents needed to be involved in the location decision — did they want the center at Robert Taylor or somewhere else? Some wanted to get away from this setting. They felt embarrassed, afraid that visitors would see this place as a reflection on them. But the more experienced mothers thought in practical terms. They thought about the weather in Chicago and how cold it is in the winter. And they convinced the others that in order to take advantage of this program's opportunities, it would be better to locate the center as close as possible to where they live.

"Families cannot give meaning to values they do not know nor provide experiences that do not exist in their environment."

We also didn't have many options. On one side of Robert Taylor we have the expressway and the railroad tracks. On the other side is what I call urban removal — boarded up buildings or completely vacant lots. But I still thought that the process of negotiating and making decisions about what would happen to them was an important experience for these parents to have. They needed to own the program.

That's also why our official name is the Center for Successful Child Development (CSCD). Nationally we're known as the Beethoven Project, a name we got because we're in the enrollment area of the Beethoven Elementary School. When I go across the country speaking, they may not know Gina Barclay McLaughlin, but when I say Beethoven, it works miracles. But in our community we're CSCD. I thought in order to feel ownership, the parents had to come up with the name, just like you name your own child. The program belonged to the families that we served. In our meetings people suggested

all these incredible names. But one parent was very convincing when she said, "You know, this has to represent success. And we really want to focus on our children." That's how we decided on Center for Successful Child Development.

I have learned a lot from this rare and unique experience. Time will only permit me to share a fraction of my new knowledge and experiences. However, since I've been in a unique spot over the last three-and-a-half years, I feel I have a very important story to share, and I'm pleased that you've invited me to share it.

The New Poverty: Deeper and More Concentrated

The mandate I have been given from the parents is that I begin to let you know that we've got to change this world. We've got to change our country. So it's with tremendous respect and appreciation and sensitivity that I share with you some of what I've learned from the people that I serve. I'm doing this in the hope that we will all gain greater understanding for the urgency to make major structural changes in our society, and in the hope that you will see the need to take a risk in order to eliminate many of the risks faced by our children and families.

I think we are all at risk, not just the people we serve. The first generation of early intervention and family support professionals didn't have to deal with the kind of concentrated poverty that has emerged in the 1980s. This new poverty clearly requires a new kind of intervention that's both more intensive and more comprehensive.

Robert Taylor includes 28 buildings. It houses 20,000 people in a two mile stretch, with 16 stories in each building. It was completed in 1962 as a part of a plan to provide decent housing to the city's low-income community without upsetting the city's segregated housing pattern. The buildings today are decaying more rapidly than they can be repaired. The activity of gangs and drug dealers leave many families in constant fear. Increasing numbers of families do not know or even wish to know their neighbors, and many only venture from their apartments when it's necessary.

Community churches that in the past were among the institutions that contributed to community stabilization have, for the most part, discontinued their investment in the neighborhood as their members moved to other communities. I am the daughter of a minister. My father had a storefront church right in the very block where our main site is located, and that whole block was condemned with the hope that they would replace it with a better kind of housing situation.

For another perspective on the quality of life at Robert Taylor we can look at social and health indicators. The median income of families is just over $5,000. Only 12 percent of households are reported to have wage incomes. Some 93 percent receive public assistance, and the great majority consist of unmarried women and their children. In one year, 300 girls — that's one-third of the class — from the target high school just across the street had babies. Forty percent of all births in the community are to girls under the age of 20; sixteen percent of the babies are low birth weight. The infant mortality rate is 28 per 1,000 live births — one of the highest in the U.S.

Children attending the community's public elementary schools score on an average at least a year below national standards for reading and math, and less than one-quarter of the students who enter 9th grade finish high school.

The Chicago Housing Project Test of Basic Skills

In designing a program to foster positive child outcomes for the Robert Taylor community, CSCD paid special attention to the differences between child-rearing patterns of the residents and those of the dominant society. The field of child development has been profoundly influenced recently by ecological theories and frameworks. Such theories stress the importance of the child's entire environment in influencing development — an environment that is far more complex than the mother-child dyad. We want to know about the context of the child's life.

I get so angry at reports — and I read one recently — comparing Robert Taylor children with children of Wilmette, a suburb of Chicago. A front page feature in the newspaper compared them and looked at competence. The article said, "Not only are they incompetent, but they raise their children to be incompetent."

I thought about that one day when I had an incredible experience. I was walking down the stairway to go to a meeting at about 8:30 in the morning just

before school started. Now imagine the setting — in the hallways, the lights never stay on because part of the whole drug traffic thing is to keep it dark so you can generate your business. So it was very dark in the hallway, and I heard rumbling from above. I hesitated and thought, "I'll let this person go ahead of me." I was relieved to see that it was a child, seven or eight years old. Unfortunately, I didn't really think about that child being overwhelmed by an adult being in this dark area at the time. I was just so relieved for myself.

The child went in front of me. Suddenly he stopped and stretched his arm out protectively. I said, "What's wrong?" He motioned and pointed. I repeated, "What's wrong?" Then I saw in the corner a rat as large as a cat standing on its hind legs. I couldn't think, I couldn't do anything. Even in the darkness he felt my fear. And he said, "It's okay. All we have to do is this." He stomped his feet, and the rat ran away.

I thought, "Thank God he was there for me." Here he was on his way to Beethoven Elementary School to add two plus three. He'll probably flunk the Iowa test. But no one would have evaluated the director of the Beethoven Project as competent after her inability to assume the adult role in this interaction. I would have flunked this test. Yet no one knows about this child's competence.

Worlds of Difference from Protected Suburban Kids

You see, I feel that unless the students of Wilmette can go to Robert Taylor and live for a year — because it takes at least a year to get this stuff in you — unless they could do that and survive, then we can't make comparisons about competence. They have a different kind of setting that they must prepare for.

Somehow I don't believe that techniques for scaring off huge rats are the kind of skills we want our children to develop. I would much rather see their energies devoted somewhere else. I don't think Robert Taylor is the kind of setting we want our children to live in. I don't think that's the kind of experience I want the children of Wilmette to have. I don't think that's what our society should represent for children.

Several months ago, early in the summer, I read a Sunday feature when I was flying to New York, about Beethoven Elementary School 6th graders who were instructed by their teacher to write about any topic they wanted to. All except two of the children in the entire 6th grade class wrote about violence. They wrote about daily shootings in their community and how terrifying they were. The newspaper published on the front page some of their direct compositions. It was very moving to me that children have to live in this kind of environment. They talked about nightmares they have, about how frightened they were. They talked about what it would be like to live in a place where they wouldn't have to worry about people shooting every day.

I think that it's a basic requirement for any society that children should feel protected. And I think that unless that happens we're all going to be frightened with the kind of future we are building by giving kids foundations in these kinds of communities.

How People Are Able to be Sane at All

So I think we need to look at children in a different kind of light than in the past. And we need to make different kinds of evaluations. We need to know more about how this kind of setting affects the lives of children. We should not spend our time comparing children. We should see what life is like for them, and look at their ability to cope in spite of the circumstances. We shouldn't even have to debate whether Minnie Thomas gets more beds. We shouldn't have to debate whether more money should go to housing so that we can have quality settings for people who need places to live.

I've been in the homes in Robert Taylor. And although I have official statistics that indicate that 20,000 people live in that complex, I have unofficial statistics that tell me something totally different. We go into apartments on a daily basis, and we see 10 to 20 people in an apartment. There are 10 apartments on each floor, and there are only two on each end of every floor with three bedrooms. Everything else has one or two bedrooms.

And so my three years in Robert Taylor have been very inspirational. Because I cannot figure out how people are able to be sane at all. I don't know what I would do in that kind of setting. I do know how it has affected all of us as staff just working eight to twelve hours a day there. I do know that anyone who has to grow up in that kind of setting will have to make some incredible adjustments in order to

function. To me it is not surprising that people find creative ways to function in an unhealthy setting. It is not surprising that one might interpret it as dysfunctional.

And so I say as we develop interventions, we've got to think about how we're tapping into the system that people use to cope and function. I'm not saying that people should function in a dysfunctional way. I am saying that we must replace their unhealthy lifestyle with something more supportive. I am not talking about parent-child interaction, even though I am a child development person who supports parents having the best parenting skills. I am talking about helping people to feel when they have not been able to feel. When they have tuned feelings out in order to survive in the settings they're in because they have no other choices. I hope we are willing to create new kinds of settings that will not further stress them out. It means that some of us will have to give up some of what we have in order for them to have a little bit more.

I hope that we are able, as professionals in the field, as people of the privileged society, to take the risks that we challenge our families to take in changing lifestyle. People say to me often, "Gina, these people have operated this way for so long. If you just give them a job . . . ." A job won't do it for them. They're dysfunctional from being in this mode. People border on saying that their dysfunction is innate, that this is who they are. What they need is support. And the kind of support they need in order to make their transition is the same kind of support that we will all need when we also change our lifestyle and give up some of our portion.

Life in the Robert Taylor Homes

In a country like the United States, with a highly diverse population, rapid social and economic changes, a history of systematic segregation of certain groups and racism and economic oppression of minorities and women, the immediate social and cultural environments of some families may not match those of the larger society. Families may be successful in preparing their children to fit into the more immediate world of the neighborhood, but not be able to prepare them for certain dimensions of life in the larger society. We've learned about that. We've had a lot of resistance from our families who've said, "You know, Gina, you want to make our kids like little white kids. We don't want them to be little white kids. We want them to be able to function in Robert Taylor. They'd get killed if they followed your remedies."

Families cannot give meaning to values they do not know nor provide experiences that do not exist in their environment. This awareness and understanding is an underlying part of CSCD's philosophy. Parents and staff try not to blame the parents for whatever kind of functioning they are involved in. What we try to do is see the interactions in the context of the environment, the cultural context and the history that family has experienced.

A wide variety of living conditions conspire to make life in Robert Taylor very stressful and difficult. I want to share some of those that I've learned about.

Airborne pollutants. The incinerators go from the sixteenth floor down to the ground level. We don't have systematic garbage collection like we have in most civilized communities. And so they burn the trash in the incinerators. You have a lot of young children, so a lot of Pampers go into those incinerators. And the burning produces huge clouds of smoke, very toxic. You almost think there's a fire in the building on a daily basis. When my husband came to the center one day and saw this, he raced immediately to call the fire department. He was frantically telling the people outside, "There's a fire here." They said, "Oh, the incinerator's burning." He said, "Gina, I'm watching people sitting on a bench eating baloney sandwiches like nothing's happening, and there's a fire here."

One of my participants has asthma so bad she can't even go out and ride the elevator. She says, "I'm afraid I'll die." Parents describe wetting towels or old clothes at night and putting them at the edges of the doors and windows to prevent the toxic fumes from coming in during the time their children are sleeping.

Overcrowding. Can you imagine for 20,000 or more people there are only two 7-11 type convenience stores in the general area? And can you imagine that this is a community where 68 percent of the residents are under the age of 25? That many children, and so few stores?

Drug trafficking and the violence attached with it. About six weeks ago I sat in an administrative staff meeting and observed a shoot-out. Every day we hear shooting, sometimes we don't know whether it's a

firecracker or a gunshot, but this goes on constantly throughout the day. And I see the same thing happening with the staff as I do with the residents. Just as my husband observed all of this smoke and no one really moving, I observed all of us counting the number of shots fired. We all kind of confirmed, "Yea, it's a gun." Some people rushed to the door to get a closer look. Others were glued to their seats, terrified. We had all experienced this repeatedly, but somehow I was able this day to observe the interaction of the group. I saw people put up their protections.

The facilitator of the meeting said, "Hey, we haven't finished this staff meeting, why is everyone getting up?" I was really angry at that initially, but I had to think about what people do to cope when they can't do anything about a situation. The staff was very aware that they had to be here at work every day. And they couldn't feel anymore. They had developed the same kind of protection that residents had developed over the generations of their existence at Robert Taylor.

That was pretty frightening to me. Somehow people have this perspective about residents who live in this kind of community, that they've earned this in their lives, they did something crazy and they wound up this way. But here we brought in a group of "healthy" professionals, successfully functioning people, and I saw the same dynamic occurring. I saw them not able to feel.

I heard the young lady from Mandela House talk about not being able to feel, and that was so real to me. See, I get to come to conferences like this, and get refueled. So I still feel the sense that this was wrong. About 30 minutes later I had to rush to a meeting. And when I went outside, it was as though the shooting had never happened. The body was cleared away, children were back out playing. And I had seen dozens of children at the time of the shooting. Our community staff, half of whom come from the Robert Taylor community, had frantically run to the door to confirm that their child was not out there in the danger. Thirty minutes later, it had never occurred.

Now, we had a shoot-out in Wilmette the year before. They flew in psychologists, psychiatrists and every kind of support person to help, and the children needed that. But this day I observed, as I observe every day at Robert Taylor, that the shooting never occurred. I saw a couple of children peeking curiously but hesitantly and in a frightened way at the roped area, the scene of the crime. But in general, everybody was playing on the playground as they normally do. And our staff certainly continued its budget meeting agenda.

The Developmental Impact of Drugs and Violence

The widespread drug trafficking is the factor articulated by Robert Taylor residents as most stressful. Drug sales are conducted openly, and residents quickly come to know the location of the drug house apartments. There's something really interesting about this because our building is right next door to one of the police units. So when you come to our center you see about 100 police cars parked out there. But it really doesn't make any difference. As a matter of fact, I've been watching closely to see if there are any sales there.

For parents, the presence of serious and obvious drug trafficking is a threat to their children. They fear that their children may be drawn into gangs or may be innocent victims of drug-trade violence. The developmental effects on children of their observation of drug use is probably a really difficult thing to calculate, but I think it would be interesting. Parents express understandable anxiety about the influence of drugs on their children's physical and mental health.

In our center we talk about physical and psychological isolation and what that means. The isolation affects the kind of interaction children need to have with adults and that they need to see adults having with each other. Because they feel so fearful, they don't get a chance to mingle with each other. They don't get a chance to see adults solving problems, adult to adult. They don't get a chance to see a neighbor or a friend taking over their children so they can have respite. Our drop-in center provides an opportunity for parents to come in and begin to develop these kinds of trusting relationships.

Part of what I see is that people don't feel very good about themselves in Robert Taylor at all. Their self-esteem is very low, and it makes sense that it would be. To try to offset that, every year we have a ceremony, a very big formal affair, to focus on the specialness of children and to develop this sense of community to support children. We're up to our third year now, and about 400 people come. The

elders come out in a procession, and then the parents are escorted to their seats by their community worker. It's feast and ceremony, the whole works, and it's a wonderful occasion.

In my group session the day after this last event, the parents seemed very angry. I couldn't figure this out. I said, "What's going on?" One parent said, "You know we got captured by that whole atmosphere — how our children are our most prized resources, how we should see them as special. But then we had to come back to Robert Taylor, and every apartment on three of the floors had been broken into. Just when we had almost bought into your reality."

It was a very powerful statement. And so I say, when we design and develop interventions, we need to think about what those mean in the context of our families' everyday lives.

The Mandela House Program: Recovering Mothers Speak

__Minnie Thomas__ is a long-time community activist from Oakland, California. She worked for many years with the Alameda County Department of Alcohol and Drug Programs. In 1987, she opened Mandela House, an innovative residential treatment program designed specifically for pregnant addicts.

The tenor of the conference changed markedly when Minnie Thomas and five young black women from Oakland's Mandela House walked up to the platform, took seats at the head table, then one by one approached the podium. In an emotional 75 minutes, these recovering cocaine addicts — all of them mothers of infants, all now members of the Oakland Crack Task Force — gave two days of facts and figures a human face. The crack epidemic was no longer an abstraction. It was Mickey, Valerie, Tammy, Patricia and Veronica — poised, well-spoken parents, glowing with newfound triumph over odds that had beaten them since childhood. Their stories illustrated the issues at hand in ways no number of charts or graphs ever could.

Mother and Infants Healing Together

Minnie Thomas, a slender black woman with an infectious smile and an intense sense of mission, spoke first, explaining how she came in 1987 to open Mandela House, a 12-month residential treatment home for women and children. For years she had worked in the criminal justice system in Alameda County, particularly with the offender and ex-offender programs. "These were really drug programs, but weren't called that," she said, "and pregnant women couldn't be taken in." She saw what happened instead: the women would give birth, and their babies would be taken away and placed in foster homes — "for the good of the child." Thomas had trouble with that rationale. "As a mother," she thought, "I'm not so sure."

From her growing conviction that these women ought to be able to live with their children as they healed, Mandela House evolved. "I never thought it would go like this," she says now, proudly announcing that she expects soon to open a second home.

"I look at myself and say, 'What kind of mother are you? During slavery they took kids away from black women. And now you give them up for rock?"

Once expanded, Mandela House will have room for 12. There is no fee to residents, each of whom enters the program during pregnancy completely of her own volition. "They've reached the point where they say, 'I am tired of what I'm doing and I want to make a change,'" says Thomas. "When I hear a woman say that, I take her in." The home operates on the philosophy that drugs are a symptom of disease. The idea is to identify the underlying problems that led the woman "to put herself into orbit," as Thomas puts it, then be creative in answering the question, "What can we do to contribute to her healing?"

Daily routines grow from that healing goal. The women rise at six a.m., groom and feed themselves and their babies, and dress in a manner suitable for an office job. "If you look good, you're going to feel good." At nine the range of classes begins — in parenting, child development, drug education, Bible studies, grooming and exercise. Each woman has an individual treatment program, and group counseling is provided by professionals from nearby Highland Hospital. The week features meetings of various 12-step programs such as Alcoholics Anonymous, and a van takes those interested to church.

Thomas, called "Grams" by the women, has been asked to name their babies. She cites the one rule about classes: "It's not mandatory that you participate, just that your body be there." For inspiration, she often repeats the message, "You can do anything you want, if you want it badly enough." And given this safe, nurturing environment — usually for the first time in their lives — one women after another, she says, comes to the stunning realization that they really can have a say in their lives.

Tales of Recovery: Learning How to Feel

With a hesitant smile, **Tammy** takes the microphone and begins her story. For 11 years, she was an IV drug user, having started on methamphetamines when her father offered them to her in her early teens. Drugs initially seemed like a refuge from pain, but led only to devastation. Tammy has five children. Two of them, a daughter and a son, were taken by authorities when she was living in a car and supporting her habit by stealing. For a while she was able to visit them, "but then they got adopted, and I will never see them again." When her next child was three she had an apartment. But her landlord — a police officer — intervened to put that child as well into protective custody. Tammy now has two one-year-olds — "and they're not twins." It was during her last pregnancy that she faced facts: "I had a drug problem, I knew it was going to affect my baby, and I didn't know how to quit."

Helped by Mandela House, she did stop. Her son was born a month early, but healthy. Tammy is now happily learning to care for him, both physically and emotionally. "I wanted him and I loved him, but I didn't know how to be patient." In fact, she explains, she had no grip on emotions at all. "On drugs you lose touch with anger, happiness and sadness. In sobriety, it all dumps on you. You feel. And then you have to learn to deal with those feelings clean and sober." Now a year into recovery, she is now a sociology student planning to work "with children, drugs and dysfunctional families." If she continues the program, she will get her older child back.

Valerie too ran headlong into raw emotions after years of self-numbing with cocaine. "My self-esteem was very, very low," she says, recalling her first weeks at Mandela. I was very angry. I did a lot of crying. I wanted to fight." She tells of childhood problems she tried to bury: sexual molestation by her father at age eight; an abiding fear of her mother that she hopes her own little daughter will not experience. After high school Valerie got a job, "but every Friday at lunch time I'd go out and get blasted." Crack, she now says, is "the most devastating drug that I experienced. People will sell their kids for it." Her pregnancy led her into recovery, and she now studies journalism and is doing a TV-news internship. "I am more than just a statistic," she asserts. "A lot of us are good people and want to do well."

Both **Veronica** and **Mickey** tried to quit drugs on their own without success. A counselor told Veronica she would need a residential program; "I thought she was crazy." Once pregnant, however, she changed her mind, and now — eight months later — she is enrolled in college courses, is caring for her baby, and feels grateful that "God was watching over me." Mickey, whose three-month-old is just starting to smile, began using drugs in the Navy and found crack's hold so powerful that even the threat of dying from drug-induced obstetrical complications didn't keep her from her next hit. With the program's help she got free of crack. And she now says she's learning positive parenting skills to replace those modeled by her own parents.

The Grown Up Child

Patricia, molested when young, succinctly summarizes the impact of an abusive childhood: "The outside grows up, but the inside stays little." Her mother was a heroin addict, her dad an alcoholic who was eventually shot in the head. Patricia married a man who beat her. At 26, she turned to drugs and soon was "on the fast-track," using and selling and changing boyfriends at a dizzying pace. She coped in another way too, by adopting an aggressive persona she named Goldie. After Goldie's boyfriend tried to kill her, she turned to blasters — a mix of crack and PCP "for a head rush." At one point she sold a boyfriend's house for $50,000 and smoked away the money in a month.

After a deep breath Patricia says, "I have eight children. And I've lost my kids." With her last pregnancy, she decided to have an abortion, "but I was too busy smoking. So I thought, well, I'll have a miscarriage." That didn't happen, and by then she was homeless. Weighing 98 pounds, she went to Mandela House, but at first there were no beds. "I

said, 'God get me off these streets, quit making me go hungry, and I'll get off drugs.'"

She has kept her word. But like the others, she now has to face up to feelings. "I look at myself and say, 'What kind of mother are you? During slavery they took kids away from black women. And now you give them up for rock?'"

Long ago kicked out of school, Patricia now shows off an extended opportunity certificate she has just earned at a junior college, "with A and B in English and math." Gleefully, she says, "Everybody should be able to walk off with something like this." When the burst of applause subsides she adds, "And I get my kids back February 2."

Workshop Highlights

The conference's 10 workshops featured experts from around the country in health, social service, education and the law. This section gives highlights of those workshops, selected on the basis of information presented that supplements, rather than reiterates, points made by the major speakers. (For a full listing of workshop presenters and an agenda showing workshop titles and sequence see appendices A and B).

Care of Drug-Exposed Infants

What has been learned so far about the impact of prenatal drug exposure on infant and child development? Are there long-term medical problems? What conditions do caregivers need to be especially sensitive to? What happens when these children begin school? Each of these issues was addressed in a separate workshop, and a composite emerged of what happens as the drug-exposed baby grows.

Focusing particularly on crack babies, health professionals reported on their observations of **newborn developmental problems**. Crack cocaine-exposed infants, they said, are fragile and hyperexcitable. They move abruptly from sound sleep to crying, then remain fussy and unable to be consoled. Their eyes don't track things well, and eye movements are erratic. They are easily overstimulated, and when in that state seem frantic and pained. And in a way qualitatively different from other premature infants, they don't make eye contact with caregivers.

These difficult behavioral characteristics may reflect enduring neurological dysfunction, according to **David Kaplan**, a pediatrician and consultant to the BAART/FACET (Bay Area Addiction Research and Treatment/Family Addiction Center for Education and Treatment) program in San Francisco. He argued that "there is no such thing as cocaine withdrawal" in newborns, since the term "withdrawal" implies that at some point the situation will pass, and he believes that neurobehavioral disorganization (manifested in infancy by such things as fluctuating states, lack of eye contact and feeding difficulties) endures. These characteristics contribute to the poor attachment that he calls "the overriding concern for the future of these infants."

To help organize and regulate the babies' responses, infant specialist **Kathleen Vandenberg** of Oakland (Calif.) Children's Hospital reported that a U.S. Department of Education funded demonstration program there called Special Start uses an approach that includes: relaxing the infants by avoiding excessive handling and protecting them from bright light and excessive noise; using special containment measures such having the mother hold her infant against her skin; avoiding abruptness and carefully planning how to gently touch and handle them; and helping them soothe themselves through such aids as tucking their hands under their chins or near their mouths.

Once the babies go home, their parents or caregivers can continue using soothing techniques, said developmental psychologist **Dan Griffith** of Northwestern Hospital in Chicago. They can try to bring the baby to "quiet alert" states through swaddling, pacifiers, vertical rocking and adjusting the intensity of stimuli. He emphasized his group's findings that drug-recovering mothers can and should be taught such soothing techniques — for the sake of both mother and child. The baby's needs call for above-average patience, something the untutored, drug-recovering mother is unlikely to give. More than that, the mother's own fragile self-

esteem requires a baby who loves back, and a crack baby often seems to cringe from the human face and touch. If the mother can at least soothe the infant, she can feel good about her mothering and pass those good feelings on to the child.

Toddler Care and the Importance of Family Relationships

And what of **toddler development**? Both UCLA's Department of Pediatrics and Northwestern University's Center for Perinatal Addiction have studied crack babies ages 12 to 30 months, and both have reported similar and troubling findings about cognitive and social development. Discussing these in one workshop, UCLA psychologist **Carol Rodning** reported finding only modest differences on structured developmental tests that compared preterm, drug-exposed toddlers with a group of toddlers from similar backgrounds who had not been drug-exposed. But when the same two groups were compared in unstructured play situations, the differences became pronounced. The drug-exposed babies were more impulsive and less goal-directed. They batted and scattered their toys rather than curiously exploring and playing with them, and they were less securely attached to their caregivers.

Peter Mangione, developmental psychologist from Far West Laboratory, reminded his workshop group that drug-exposed children, like all children, are unique individuals who "will benefit greatly from caregiving that is attuned to their individual needs and temperamental style moment by moment." He outlined the major indicators of temperament for young children — summed up in his accompanying video as "flexible, fearful or feisty" — and spoke of how individual infants and toddlers vary within each. "Expect the unexpected," Mangione said. "Just because a child tends to display a particular behavior or reaction doesn't mean he will never change."

High-quality relationships between child and caregiver are the primary concern of **Jeree Pawl** of San Francisco General Hospital. The Infant-Parent Program she directs attempts to identify all factors, not just drug use, that may be compromising that quality. "We ask ourselves whether or not — even if drug free — many of the life experiences which have led to the use of drugs would not also have an influence on the mother-child relationship," she said. As an example, she told a poignant story of troubles between a drug-recovering mother and her toddler. "The same impulsivity, irresponsibility, lack of planning and search for a quick fix that were hallmarks of her drug use are also part of her relationship now to her daughter." With intervention, Pawl has seen such relationships improve. "But services are limited and often badly overstressed. This keeps professionals from doing the good job that they could."

Much of Pawl's message was echoed by **Nika St. Claire** of the C.A.R.E. (Chemical Addiction Recovery Efforts) Clinic at Oakland Children's Hospital's Center for the Vulnerable Child which offers comprehensive services for the infant, mother and "the high-risk dyad and family" under one roof. Each family has its own case manager, and services include pediatric care, developmental assessment, parenting education, weekly parent support group and individual, couple and family counseling. St. Claire and her staff believe that "it is past time to abandon the self-fulfilling prophecy that addicted mothers make bad mothers" and instead view the addictive mother as a person capable of growth and change. To be successful, the therapist working with the family must have empathy, respect, concreteness, potency, knowledge — a tall order. "Although working with such families is very difficult, it is also tremendously rewarding. Our interventions can and do make a difference in the quality of life for our children and their families."

Following These Children to School

How are these children faring by preschool age? According to educator **Carol Cole**, they are neither atypical nor dissimilar from other vulnerable children. "However," she added, "the combination of both organic and environmental insult leaves these children in need of specialized curriculum and services." In 1987 Cole and her colleague Vicky Ferrara, both teachers in the Los Angeles Unified School District, developed there a pilot program for three- and four-year-olds who were prenatally exposed to drugs. The program aims above all to build trust, a prerequisite for security and moral development.

Cole explained that most of the 23 children in the program have a history of poor attachment and lack of trust. On average they have lived in three different foster homes by the age of three. So although prenatal drug exposure may partially explain sensitivity, passivity, hyperactivity, apathy or

aggression, these behaviors may also in fact spring from the pattern of instability in their lives. Teachers, then, need to establish strong relationships with each child and family. Modeling concerned nurturing, predictable interaction and respect for feelings is more important than teaching colors, numbers or letters.

Vicky Ferrara told of following the first group of preschoolers from their special education preschool campus to kindergarten at a regular elementary school. She not only helped mainstream these kids, but found that strategies from the pilot program were helpful to kindergarten, first and second grade teachers working with "difficult" students who may or may not have been drug-exposed. The three major strategies, she said, are transition plans, play and home-school partnerships.

When making **transitions** from one activity to another teachers announce that the activity is about to end and help ease kids into the next one. If an assembly or a visitor is scheduled, children discuss the event in advance so that they are well prepared and can control their behavior. Watching play allows teachers to see how young children integrate their cognitive, language and social skills. And a **partnership with the primary caregiver** helps with trust building. Information can be shared about changes at home or school that will affect the child. And teachers can learn about important factors in a child's behavior such as poverty, abuse or violence.

Social Services and Foster Care

Increased numbers of drug-exposed infants needing foster care have utterly overloaded the caseloads of child welfare workers. **Sharon Miller** of the California State Department of Social Services reported that more than 74,000 children are currently in foster care in California. That's a 37 percent increase since 1987, largely as a result of the crack epidemic.

Mari Louise Payne, a case manager with San Francisco's Department of Social Services (DSS), described that city's recently developed Fragile Infant Special Care Program (FISCP). This program develops appropriate foster home placements for infants acutely ill from prenatal drug exposure, HIV infection or other serious illness. FISCP includes a stringent selection process and 10 weeks of training for foster parents in both the medical and psychological problems they must be able to handle. But the costs of state care for these babies is "astronomical," Payne said. Far better that they be maintained in their own families with the help of community resources and support services.

Mark Claycomb wholeheartedly agreed. As program manager of the In-Home Family Care Program of San Francisco's Children's Home Society, Claycomb told of striving to keep children in their homes by working to make those homes safe and nurturing places. Families served are either at risk of losing their children to protective services or are trying to reunify with children already removed. Most have problems with addiction. The program teaches such things as parenting skills and household management and links families with needed resources. Staff members have the same ethnic backgrounds as clients, and many grew up in the neighborhoods served. They assist just four to five families each (as opposed to the 40 or 60 handled by DSS workers), and families regard them as trusted friends.

A few programs are taking a collaborative approach to in-home, preventive work. For example, public health nurse **Vicki Kropenske** of UCLA reported that the Department of Pediatrics there has pioneered the interagency, interdisciplinary T.E.A.M.S. Outreach Training Project which trains child protective service workers (CPSWs) and public health nurses (PHNs) to work as a team. The partners then support drug-exposed infants and their caregivers in the various neighborhoods of Los Angeles. A shortened version of the training program is now being offered in selected counties throughout California.

In San Francisco, the Parent-Infant Neighborhood Center, a 17-year-old provider of daycare and developmental, health and nutritional services for abused and neglected infants, has developed the Inter-Agency/Family and Community Support Network Demonstration Project, according to director **Melvin Miles**. The project uses culturally sensitive, community organizing tactics to building networks of social support among risk groups in their own neighborhoods.

Working With the Pregnant Addict

But what of the pregnant addict? Though she may be highly motivated to seek treatment, she faces a critical nationwide shortage of treatment programs able to serve her adequately. Part of the reason is

that the number of pregnant addicts has risen rapidly since crack cocaine arrived on the drug scene. But there is also the issue of providing the specialized treatment these women require. **Janet Chandler**, a chemical dependency specialist who works with Ira Chasnoff at Northwestern Hospital's Center for Perinatal Addiction, explained the dilemma as two-tiered: the client faces both **the developmental tasks of pregnancy and the tasks involved in freeing herself from chemical dependency.** And she is often a very vulnerable woman whose chaotic childhood left her low in self-esteem and impulse control.

Chandler said that most of the women her program are African-American, on public assistance and are crack users. On average they come in around the eighteenth week of their pregnancies, often because the first movements of the fetus break through their denial of pregnancy and fill them with guilt and remorse. In individual, family and group counseling they examine their feelings about motherhood. They are helped to grasp the reality that there is an infant, a being separate from themselves. Through artwork, they often discover and assess unconscious fantasies — "The baby will make me straight," for example, or "will make the father love me." Meanwhile, they reawaken long drug-clouded feelings of self. "Until they stop using drugs, a sense of self is almost impossible," Chandler said.

Clinical psychologist **Barbara Wallace** added that when the self is revived after lengthy drug use, the woman is "like a raw nerve exposed." To avoid relapse, the therapist must begin educating her immediately about "conditioned cues" that may trigger using drugs — her bedroom, for example, or her best friend's presence. She must learn strategies for handling cravings, and the therapist can help by offering metaphors: "Imagine what it was like to always be on guard for the lookout man." More fundamentally, she must gradually examine her problems in order to resist falling prey again. Perhaps her low self-esteem traces back to an alcoholic parent. Or parents who didn't give her a sense of her specialness. Whatever her history, the therapist must convey that her current state of deterioration due to drug dependence has made her the more vulnerable.

A professor at John Jay College in Manhattan, Wallace is a clinical psychologist who has worked with over 300 pregnant, "out-of-control" crack addicts with $100-200 a day habits. She emphasized that the therapist must have empathy. The severe addict's physiological and psychological demand for crack is intense. Cravings upon withdrawal will make it "almost impossible for them to quit the drug on their own." Many clients require inpatient detoxification for 14 days. For some, outpatient care can then suffice. But chronic users need prolonged residential treatment. "Putting them out would be absurd — like putting a porcelain glass on the edge of a table."

She earmarked three to six months as the most critical period for either residential or out-patient treatment, depending on individual assessment. But she noted that the entire first year of abstinence is full of peril and stressed that pregnant women who relapse must have the option of re-entering detoxification or residential treatment. The ideal program, she said, would have affiliated inpatient, outpatient and long-term, variable-length residential components through which patients could rotate. It would recognize that "this population is not monolithic. Assessment is crucial. And the program is cost-effective when you don't recommend the same treatment for everyone."

Ethics, Law and Policy

Bills before Congress and several state legislatures would mandate criminal sanctions against pregnant women who use drugs. The stated intent is to protect the children, but **Marty Jessup** — a nurse, chemical dependency specialist and co-founder of California Advocates for Pregnant Women — insisted that "unless we do something to help the women we are not going to do anything to help the children." She asserted that the moves toward criminalization have the hidden agenda of helping roll back reproductive rights. "Instead of prosecuting a class of women who have not had treatment alternatives, we should have full, affordable and accessible treatment for their disease."

As for what's possible under the law, **Donald Bross**, a professor of family law at the University of Colorado School of Medicine said that the law has viewed the child's life in stages — pre-conception, conception, embryo, fetus and neonate — and has responded to each stage differently. He outlined precedents set, and concluded by citing data from Northwestern's Perinatal Center for Chemical

Dependence that prenatal intervention for pregnant addicts dramatically cuts the average hospital stay for infants. "When a parent will voluntarily agree to court-approved and ordered services, or when a clear legal basis for involuntary intervention is established, treatment services can make a difference."

Michael Durfee, a physician and medical coordinator of the Los Angeles County Child Abuse Prevention Program, seconded the idea that criminal sanctions may not mean "locking someone up" but rather ordering her into care. He called upon the legal system to establish clear legal rights for grandparents who become the caregivers of babies born to addicts. And he outlined a prevention role for all players — from law enforcement officers referring families to crisis intervention to schools educating kids about drugs.

Schools and Prevention

But do school-based prevention programs really work? They do if they're done right, reported **Carol Burgoa** of the Western Center for Drug-Free Schools and Communities. First, she offered what 25 years of experience has shown does not work. For example, information-only approaches that teach kids drug pharmacology, effects and legal consequences do not change behavior. And scare tactics using overblown data don't wash, especially since kids universally believe "it will never happen to me."

To be effective, she said, drug education must be part of a comprehensive health education curriculum which in turn must be part of a comprehensive, community-wide prevention effort. There must be clearly stated objectives that affect knowledge, attitude and behaviors, and these must be clearly related to drug use. Curriculum content must contain the "short-term, social, salient" consequences of use as well as teach such things as communication, decision-making and friendship-developing skills — all in the context of drug-use prevention and all taught by well-trained teachers.

Influences of peers, family and media should be identified. Kids must be given practice in goal-setting, values identification and critical thinking through role-playing, Socratic questioning and cooperative learning situations. Didactic instruction should be avoided. "We must teach students that most kids their age do not use drugs and do not consider using drugs acceptable behavior."

Co-panelist **Ira Sachnoff** of the San Francisco Unified School District's Peer Resources Program stressed the value of getting kids to help each other, especially at the high school and middle school levels, since "teenagers have a 'built-in' understanding of the problems facing their peers." And for school administrators overwhelmed by the thought of setting up so comprehensive a plan, San Francisco State University professor **C. Lynn Fox** offered an already-proven model she helped design called Project STOP (Standing Together to Offer Prevention). An adaptation of its five phases — needs assessment, planning, implementation, evaluation and dissemination — forms the basis for the approach Burgoa and her colleagues use in extensive trainings throughout the West.

A Political Overview From California

Whether the crisis of drug-exposed babies will persist or abate depends largely on what happens politically. Two members of the California state legislature — Senator Diane Watson (D-Los Angeles) and Assemblywoman Jackie Speier (D-San Mateo County) gave their views on the prospects of seeing comprehensive legislation enacted in that bellwether state.

"Gloom and Doom"

Watson began with by outlining the enormous burden this crisis places on the state's health and social services systems. More pregnant women are showing up for medical care only at the time of delivery. They are coming straight to emergency rooms, where costs are always higher, and their lack of prenatal care is translating into far more complicated deliveries. Since most of these women are indigent and uninsured, costs must be borne by MediCal, the state's health program for the poor. More than that, said Watson, hundreds of crack users are now delivering in emergency rooms under assumed names and then vanishing, leaving their infants — who are often very ill — to become wards of the state.

The human costs are incalculable, but the state estimates its dollar costs for drug-exposed infant care at $178 million annually. Expenses after that only begin with ongoing medical bills. Referrals to county child welfare programs for abuse and neglect increase, since many of the parents get no help for their addictions. The costs of foster care and special training for foster parents soar. And as these children reach school age, possible behavioral and learning disabilities will require special education services.

"We need change in the administration and the legislature so that we face the future instead of being fixated in the past."

California, Watson noted, does have a number of general health programs serving low-income women and children. Included in these are comprehensive perinatal services, prenatal care guidance and adolescent family life programs. The Department of Alcohol and Drug Programs also provides county block grants for alcohol and drug treatment programs. And the Department of Developmental Services follows infants at risk of developmental disability to ensure needed medical and social services. But the continually growing numbers of drug-exposed babies, she said, "gives us frustrating knowledge of how inadequate our services really are."

Despite this message of "gloom and doom," she said, "we are starting to act. But our focus is still on the back end rather than on prevention." For that she blamed the legislature and, in particular, Governor George Deukmejian. "In the the midst of an epidemic, he would cut off funding for family planning. That is the utmost in short-sightedness and close-mindedness."

Where the Hope Lies

Without a doubt, said Watson, the most effective way to address this problem is through a comprehensive, multi-disciplinary delivery system. To her, this ideal system would include outreach and preventive education, early identification of maternal substance abuse, interagency case management of substance-addicted women and their substance-exposed infants, uniform screening protocols for substance exposure in labor and delivery, consistent reporting to local child welfare services, family education, parenting services, referral to residential substance abuse treatment programs and special training for foster care families.

To achieve all of this, policymakers can increase, target or better coordinate resources to high-risk women and infants. Legislation can remove barriers to comprehensive service delivery. "But what we need is the political will. We need change in the administration and the legislature, so that we face the future instead of being fixated in the past."

She did, however, note certain legislative steps that she feels are in the right direction. For example, chemically dependent pregnant women and their babies were the focus of two informational hearings and two legislatively sponsored public policy conferences. This attention was prompted in part by a bill that Senator John Seymour (R-Anaheim) introduced, calling for treatment programs and prosecution penalties for substance-using women who give birth to addicted babies — a punitive approach that Watson does not support. The legislature has also enacted Watson's own bill (SB 990) providing for the transfer of licensing authority for residential drug treatment facilities for adults from the Department of Social Services to the Department of Alcohol and Drug Programs. This move, she says, will pave the way for "more innovative and creative programs."

A Comprehensive Bill

Assemblywoman Jackie Speier was as critical as Watson of her state's existing political mindset. "We have 30,000 kids a year in California born to addicts, and the state is doing embarrassingly little," she said. In an effort to counter that inaction, Speier polled experts in the fields of perinatal addiction and maternal and child health, asking for their thoughts on what the legislature could do. Their message, she said, was clear. "They said the legislature must take a leadership role in affirming that this is a crisis. It must focus everyone's efforts on recovery opportunities for women who have alcohol and drug problems."

She also heard certain cautions. The state should recognize, for example, that not all counties' needs are the same. Those just getting underway need planning and technical assistance; those further along and need money for recovery programs. There should also be an awareness that the prenatal care system is not capable of dealing with addiction and that — conversely — the recovery system is not able to deal with pregnancy. And because of the nature of the problem, California's response must be long-term, not short-term.

The result was AB 741, Speier's bill entitled the Alcohol and Drug-Affected Infants Act. She described it as having three simple steps: 1) Train health and social service workers to sensitively identify women at risk; 2) Expand state capacity to provide treatment and support services, including health care, child care, transportation and family visitation; and 3) Coordinate the alcohol, drug and social services offered by the state and the various counties.

The bill passed in the Assembly and won a unanimous vote in the Senate, but was defeated by Governor Deukmejian whose position is that no one yet knows how to help pregnant addicts. "Doctors, nurses and counselors told me we do know what to do," said Speier. "What limits us is a lack of state commitment to do it." Noting that 5400 women are on waiting lists for treatment programs, she added, "The victims will be a generation of children." Though in two terms Deukmejian's veto has never been overriden, Speier vowed to try and believes she can succeed. "I should tell you, though," she said, "I also believe in the tooth fairy."

APPENDIX A

Agenda

Conference Introduction

Susana C. Mata, Ph.D., Director,
Drug Free Pregnancy Conference, FWL

Invocation

Rev. Leontine Kelly
Retired Bishop, United Methodist Church

Conference Welcome

Dean Nafziger, Ph.D.
Executive Director, FWL

An Overview of the Crack Cocaine Problem

Diane Watson
California State Senate

The Impact of Crack Cocaine and Other Drugs on Mothers and Children

Margaret Lynn Yonekura, M.D.
UCLA-Harbor Hospital

Creating Comprehensive Services for Pregnant Substance Abusers

Jackie Speier
California State Assembly

Intervention, Treatment, and Policy

Moderator
J. Ronald Lally, Ed.D.
Director, Center for Child and Family Studies, FWL

Panelists
Xylina Bean, M.D.
King-Drew Medical Center
Los Angeles

Neal Halfon, M.D., M.P.H.
Oakland Children's Hospital

David F. Chavkin, J.D.
National Center for Clinical Infants Programs,
Washington, D.C.

The Mandela House Program: Testimonies From Recovering Mothers

Moderator
Minnie Thomas
Director

Panelists
Recovering Mothers

Generations At Risk to the Nightmare of Addiction

Gina Barclay-McLaughlin, Consultant

Workshop 1: The Impact of Drug Exposure on the Development of Infants and Toddlers

David Kaplan, M.D.
Pediatric Consultant

Carol Rodning, Ph.D.
UCLA

Kathleen Vandenberg, M.A.
Oakland Children's Hospital

Workshop 2: Prevention Efforts in the Public Schools

Carol Burgoa
Prevention Training Specialist
Western Center for Drug-Free Schools and Communities, FWL

Ira Sachnoff
San Francisco Unified School District

C. Lynn Fox, Ph.D.
San Francisco State University

Workshop 3: Health Issues of Alcohol and Drug-Exposed Babies

Sylvia Villareal, M.D.
San Francisco General Hospital

Donald Wong, M.D.
San Francisco General Hospital

Workshop 4: Working With Families Impacted by Addiction

Kathleen West, M.P.H.
EDEN Center
Los Angeles

Nika St. Clair, M.S.
Oakland Children's Hospital

Workshop 5: Ethical, Legal, and Policy Implications of Substance Abuse During Pregnancy

Donald C. Bross, J.D., Ph.D.
University of Colorado

Marty Jessup, R.N., M.S.
First Hospital
Vallejo, California

Michael Durfee, M.D.
Los Angeles County Child Abuse Prevention Program

Workshop 6: Caring for Drug- and Alcohol-Exposed Babies

Dan Griffith, Ph.D.
Center for Perinatal Addiction
Chicago

Peter Mangione, Ph.D.
Center for Child and Family Studies, FWL

Jeree Pawl, Ph.D.
San Francisco General Hospital

Workshop 7: Following Drug-Exposed Babies to School

Carol Cole, M.A.
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Workshop 8: Social Service and Foster Care Issues

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Workshop 9: Chemical Dependency Treatment for Pregnant Addicts

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Workshop 10: Building Coalitions and Interagency Collaborations

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APPENDIX B

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